			1 - For Amend #5,	State o per FH G88	f Marylan 2 8/12/	d / Depa 08 TT Ce	artment of H	lealth a Death	and Men	tal Hygi	ene 2 0	08	24	501
			1. Decedent's Name (First, Midd	lle, Last)						Date of Death Month	n D <i>a</i> y	Year	3. Time o	of Death
	Physici /Medio		Richard	Christophe	er Pr	oto				ily 27,			4:45	a ^M
	Examin		4a. Facility Name (If not institution	on, give street and nur	mber)		4b. City, Town, or	Location of	f Death		4c. County	of Death		
1			6409 Four Foot					umbia	2411-2		Н	ward		
	Funeral		5 Social Security Number	6. Sex 1 🔯 M 2 🗆 F	7. Age (In yrs. 68	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth Month, Day,		Count		or Foreign
	Director		198-30-6991 Usual Residence of Decedent		- 00				F	eb. 9,	1940	C'.	Γ	
4	# 6		10a. State 10b. County	/	10c. Cit	ty, Town or Lo	cation					10	d. Inside C	City Limits
	ied s	to	PA Fra	nklin			Mercers	hura					1 ☐ Yes	s 2 No
4	r 28a	Director	10e. Street and Number				10f. Zip Code	barg		10	g. Citizen of W	hat Counti	ry?	
1	23a o St be	a D	14007 Maple Wa	У			1	7236			United	Stat	tes	
0	Sme F mu	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U	.S. 13.	Was Decedent of H		gin? (Specify	Yes or No-	14. Race	e - America k, White, et	an Indian,	
စ္က	or it		1 ☐ Never Married 2 ☐ Ma	rried 1 Tes	2 💢 No		1 ⊡Yes 2 🔯 No	Specify:	, r derio micu	11, 610.)	Specify:		C.	
d 21215-0036	min 7.2 frous are death will the way yat e. an "natural", or items 23a or 28a-f show Madral Examiner must be notified at	d by	3 ☐ Widowed 4 🛣 Divorce	d Year or D	ates:							Wh:	ite	
5	"nat	Completed	15. Decede (Specify only high	nt's Education est grade completed)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most	of working		6b. Kind of Bu	siness/Indu	ustry	
12	than	Ę.	Elementary/Secondary (0-12)	College (1	-4or 5+)		nsultant	1)			Dept.	of Do	efona	_
2 2 3	tral Hygien d other the event, the		17. Father's Name (First, Middle				I I SULL COLLC	18. Mother	r's Name (Fir	st, Middle, M	laiden Surnami		stense	e
au au	× 2 00 0	o Be	Matthew Proto					Cel	leste S	Starla	771	,		
2	h and Mental I	은	19a. Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address (Street					State, Zip (Code)	
, Mg	alth a 27 is 27 is		Ellen Rabe - P	artner		6409	Four Foot	t Trai	il Co	lumbia	Marvil	and 1	21045	
e.	- T % =		20a. Method of Disposition		20b. F	Place of Dispo	osition (Name of matory or other place	:e)	July Date		20c. Location -			
E S	nent of int: If It iry or o		1XXBurial 2 ☐ Gremation 4 ☐ Donation 5 ☐ Other (State		lge Mem. 1	i	31, 20	008	Elkridg	re. Ma	arvla	nd
Baltimore, Maryland 21215-0036			21. Signature of Fune al Service	Ligensee MQ	0053		2. Name and Addre				ufman F			
n s	70 E E 9		Hauts	415uh	ande	M	IP, Inc.,	7250						
			23a. Part1 ter the disease, of shock, or heart failure. Lis	or complications that c	aused the deat	h. Do not en	ter the mode of dyir	ng, such as	cardiac or res	spiratory arre	est,	-	Approxima Interval Be	ate
P	hysician		Immediate Cause (Final disease or condition	li	1	Can	10/						Onset and	
1	/Medical		resulting in death)	Due to	or as a conseq	uence of):							7	√
E	xaminer	L	Sequentially list conditions	b	U									
Pa	sit.	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):								
6U,	and I-tran	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseq	uence of):								
,00/	physician and is the burial-transit			255.5	(01 00 0 0011004	de1100 01).								
20 25	phys s the	edical		d										
BOX	nding use a	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna	ancy					23d. Date	e of deliver	ſV	
ň tag	a atte	icial	in the past 12 months? 1 □Yes 2 □ No	4 ☐ Pregi	birth 2☐Feta nant at time of o		☐ Ectopic pregnanc ☐ Other (specify) _	У			Moi	nth [Day	Year
ָרָ ס	by the	hys	9 Unknown	9 ☐ Unkn	own									
S that	gned e det	by P	Part II. Other significant condit	ions contributing to de	eath but not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did tob	acco use contr	ibute to the	e cause of	death?
COLOS	en sig									1 ☐ Ye	s 2 No	3 Proba	ably 4 🗌	Unknown
ecc §	as be 2 sho	Completed								24a. Was an		Vere autop	sy findings	s available
r e	ate h page	E O								perform	ied? d	leath?	2 □No	cause of
VITAI	ertific ctor,	Be	25. Was case referred to medica examiner?					26. Place	of Death (Ch					
OT V	this o	၉	1 Yes 2 No	Hospital: 1 🗆 I	Inpatient 2	'		4 LI Nui	rsing Home	5 🗌 Reside	nce 6 Othe	er (Specify	Francis	ne
ina F	After	ü	27. Manner of Death Natural 5 ☐ Pendi	ng 28a. Date	of Injury th, Day, Year)	28b. Time o Injury	Worl		i	Describe hor	w injury occurre	ed		
VISION	for: / the f	cati	2 Accident invest	Inot be				Yes 2□N	-					
N N	Direc Direc in by	Certification:		mined 28e. Place	of Injury - At he ng, etc. (Special	ome, farm, str fy)	eet, factory, office			Location (Str City or Town	eet and Numbe , State)	er or Rurai	Route Nur	mber,
pital	eral l		29a. Certifier	ing Physician: To the	heet of my kn/	wledne deat	h occurred at the tir	me date an	d place, and	due to the co	ausa(s) and ma	nnor ac et	ated	
Hos	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical		Examiner: On the b										(s)
70 th	within To the	Me	29b. Signature and title of certific	ər			29c. Licens			29	d. Date signed	(Month, D)ay, Year)	
D	5		▶ CB	1	u,D		14	113	9	L	uly ?	19 Th	,)	800
	17)		30. Name and address of person	who completed caus		n 23a) (Type,	Print)		-	U	110		1	- 0
			11065 Little	Patuxen	1 Pkw	y Cole	umbia K	1d. 21	1044					
	Sta		31. Date filed (Month, Day, Year	2008 3 R	egistrar's Signa	ture A	anti s				·			
	Registr	ar			1000	4	-60							

DHMH 17 Rev 1/2001

			For State Registrar	State	of Marylar		artment of H rtificate of I			gienez Reg. No.	800	24502
2	Physici		1. Decedent's Name (First, Midd Arnold Da		h				2. Date of De Month July	Day	Year 2008	3. Time of Death 12:25p M
	/Medic Examin Funeral Director		4a. Facility Name (If not instituti 6223 Oakland I 5. Social Security Number 220–40–9190			last birthday) Yrs.	4b. City, Town, or Sykesvi If Under 1 Year Months Days		ath	4c. Co Ca	punty of Death rroll 9. Birth	place (State or Foreign
pa-303	ō		Usual Residence of Decedent 10a. State 10b. Count	у		ty, Town or Lo	ocation		Kpi Z	, 1)4		10d. Inside City Limits
	th the Ma or 28a-f s e notified	Director	MD Ca	rroll			Syke	esville		10g. Citizer	n of What Cou	1 ☐ Yes 2 No ntry?
36	should be filed within 72 hours after death with the Maryland of Mental Hygjene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notifiled at	by Funeral [6223 Oakland 11. Marital Status 1 Never Married 2 Marital Status	12. Was Der Armed F Irried 17 Yes	cedent Ever in U forces? 2 No live 1067		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	21784 ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		USA Race - Americ Black, White,	
21215-0036	d within 72 hou giene. er than "natura the Medical E	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education est grade completed		(Give life.	dent's Usual Occup kind of work done of DO NOT use retired ody & Fend	during most of w	Ü	16b. Kind	of Business/In	•
Maryland (be d d	To Be C	17. Father's Name (<i>First, Middle</i> Arnold	James Pari	rish				lame <i>(First, Middle,</i> Lta Margr		,	.11e
	ges 1 and 2 should it of Health and Mer if Item 27 is marke or other traumatic	ľ	19a. Informant's Name/Relation	, , , , ,	(Wife)		ng Address <i>(Street o</i>					
altimore,	Pages 1 ann of He		20a. Method of Disposition ↑ Burial 2 □ Cremation 4 □ Donation 5 □ Other		State		osition (Name of matory or other place pel Cemet	1	Date /29/08		tion - City or T allstow	
Balt	permit. Page Department of Important: If any Injury or once,		21. Signature of Funeral Service	e Licensee L. Hargy	- 400	Dec H	2. Name and Addre IAIGHT FUN ykesville	VERAL HO	OME & CHA			
58760,	Physician Medical Examiner buhasician and physician and physician and street the prival-transit	edical Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in Jeath) Lact	a. Due to	o (or as a consection of or as a consection)	quence of):	0 -	200 (588)	cve as			Approximate Interval Between Onset and Death
.O. Box (eath certif attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome pf pregn birth 2 Pet gnant at time of nown	al death 3	⊒Ectopic pregnancy □ Other (specify)	100		230	d. Date of deliv	very Day Year
Д.	w requires that the d been signed by the should be detached	by	Part II. Other significant condi	tions contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	\ \		the cause of death?
Vital Records,		e Completed	25. Was case referred to media	al	_			26 Place of F	24a. Was auto perfo	psy ormed? 200 No		opsy findings available ompletion of cause of 211No
Division or Vi	ing Phy After this uneral d	ation: To Be	examiner? 1 Yes 2 No 27. Manner of Death 12. Natural 5 Pend 2 Accident	Hospital: 1 28a. Date (Mo	Inpatient 2 [e of Injury nth, Day Year)	ER/Outpatien 28b. Time o Injury	f 28c. Injur Wor	er: 4 🗆 Nursing	\sim	dence 6 [Other (Specioccurred	ify)
DIVIS	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Certification:	4 - Hornicide	mined 20e. Flat buil	ding, etc. (Spec	ify)	reet, factory, office	- 94	City or To	wn, State)		ral Route Number,
	the Hosp thin 24 hou the Fune mpletely fi	Medical	(Check only 2 ☐ Medica		basis of examin nner stated.	ation and/or ir	ivestigation, in my o	opinion, death o	ccurred at the time	, date and p	lace, and due	to the cause(s)
)	¥ <u>1</u> × 2 ⊗		30. Name and address of persons of the control of t	. Olet	-1 a	10	29c. Licens	272	//	250. Date s	signed (Month	108
	10		30. Name and address of person Stoven (S.//)	n who completed cau	Ise of death (Ite	m 23a) (Type,	& tom	Gud 1	Adors	0418	MD	21784
	Sta Registi		31. Date filed (Month, Day, Yea	2008	Registrar's Sign	K do	ade					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 0 0 8 For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day 7. 2008 Physician July PELC /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE JEWISH CONVALESCENT & NURSING BALTIMORE 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/16/1916 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Hours 10XM 2□ F **POLAND** 92 073-26-9548 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a, State 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Modical Examinar mast be notified at 1 ☐ Yes 2 🛣 No Funeral Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7920 SCOTTS LEVEL ROAD 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Black, White, etc. and 2 should be filed within 72 hours after of teath and Mental Hygiene. m 27 Is marked other than "natural", or Itar 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Completed by 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SUPERMARKET MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PELC LIEBERMAN SARAH YAKOV MENDEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14 OLD CREEK COURT, OWINGS MILLS, MD ISRAEL PELC / SON Department of Health Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD BETH TFILOH CONG. 07/29/2008 ' 4 □ Donation 5 □ Other (Specify) injury 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature Funeral Service Acensee any ir 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death yoreschiel withinh Immediate Cause (Final 15m14 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a mequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as ont Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check on one Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide within 24 hours a 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) 32 Registrar's-Signature State 2008 JUL 3 0 Registrar

			State of Marylan		artment of H			giene Reg. No.	800	24504
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Grace Plimack		AL City Town	Lanction of Dogth	2. Date of Dea Month	Day 2-6	Year O P	3. Time of Death
)	Examin Funeral	er	4a. Facility Name (If not institution, give street and number) 5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	Location of Death Location of Death Mill Under 24 Hrs. Hours Min.	8 Date of Birt	Ca	2//oll	ce (State or Foreign
¥	Director		Usual Residence of Decedent	Yrs. ty, Town or Lo			(Month, Da 07/05)	/1918	Country 10d	I. Inside City Limits
	th the Mary or 28a-f sh e notified a)irector	MD BALTIMORE 10e. Street and Number	BALTIM	10f. Zip Code			10g. Citizen	of What Country	1 □ Yes 2 X No
20	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. A 1s marked other than "natural" or Items 23a or 28a-f show deher traumatic event, the Medical Examiner must be notified at	by Funeral Director	1500 BEDFORD AVENUE, #214 11. Marital Status 1 □ Never Married 2 □ Married 3 ☼ Widowed 4 □ Divorced 1500 BEDFORD AVENUE, #214 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	21208 lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	E	USA Race - American Black, White, etc	C.
9500-6171	within 72 houn ene. than "natural" he Medical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired SALESI	during most of wor d)	king	16b. Kind o	f Business/Indu	stry
=	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) SAMUEL RAS	KIN		18. Mother's Nan		Maiden Suri	name)	NKIN
Ž	and 2 should lealth and Men m 27 is marke her traumatic o		19a. Informant's Name/Relationship (Type. Print) JOYCE GOETZ / DAUGHTER	3402	ng Address (Street		BALTIM	ORE, M	D 2120	8
Dallilliore	t. Page ntment o ntant: If njury or		20a. Method of Disposition 1	AITZ	osition (Name of matory or other ola EMUNAH CHAIM 2. Name and Addre	07/2	9/2008	BALT	IMORE,	MD
D D	permi Depar Impor any ir		23a. Part 1. Enter the disease by combications that caused the deal	14	8900 REIS	STERSTOWN		PIKES	VILLE,	
)	Physician /Medical		shock, or heart failure. List only one cause on each fine Immediate Cause (Final disease or condition resulting in death) Due to (or as a consection)	Quence of):	EDA: 11					Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate gause. Enter Unorflying	quence of):	fibrilla	tion				
,007	ate be executed hysician and the burial-transit	ical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C	quence of):						
O. BOX 00	ding Physician: The law requires that the death certificate be executed n. h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ■ No 9 □ Unknown 23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of o	al death 3	□Ectopic pregnanc □ Other (specify) _	у		23d.	Date of delivery	y Day Year
cords, P.	quires that to signed by all be detail		Part II. Other significant conditions contributing to death but not res	sulting in the u	underlying cause giv	ven in Part I.				cause of death?
meco	The law recate has bee page 2 shor	Completed					24a. Was auto perfo 1∐ Yes		prior to com death?	sy findings available pletion of cause of
V II.	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No]ER/Outpatie	nt 3□ DOA Ott	ner:	ath <i>(Check only d</i> fome 5 ☐ Resi		Other (Specify)	
ם ווסו	Attending Phy ir death. ector: After this by the funeral of	-	27. Man r of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inju		28d. Describe			
NIVIS:	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At h building, etc. (Special Country of the suilding, etc.)	ify)			City or To	wn, State)	umber or Rural	
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical	29a. Certifier 1√ Certifying Physician: To the best of my kn (Check only one) 2 Medical Examiner: On the basis of examin and manner stated.							
	within comp	Me	29b. Signature and title of certifier		29c. Licen			29d. Date si	igned (Month, D	
1	1		30. Name and address of person who completed cause of death (Ite	m 23a) (Type	, Print)	1339 mins 4/1		1/2	6 200	0
0			31. Date filed (Month, Day, Year) 32. Registrar's Sign	I Avy	. West	nins ter,	MD 21	157		
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Sign	de.	Erael ,					

DHMH 17 Rev 1/2001

			1 - For State of Maryland		artment of H			iene g. No. () (8 (24505
ì	Physici		1. Decedent's Name (First, Middle, Last) Angeline Rollins				2. Date of Deat Month July	Day	Year	3. Time of Death 5:00 PM
>	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) Futurecare Northpoint		4b. City, Town, or Baltimon			4c. County of Death Baltimore		
F	Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. In 2 X F 79) Usual Residence of Decedent	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 14,	^{Year)} 1929	9. Birthpl Count Mary	ace (State or Foreign ry) Land
	e Maryland a-f show iffied at	ctor	10a. State 10b. County 10c. City,	Town or Lo					10	0d. Inside City Limits 1 X Yes 2 □ No
	with the	i Director	10e. Street and Number 3410 Mt. Pleasant Ave.		10f. Zip Code 21224	40		og. Citizen of ' United		
36	d within 72 hours after death with the Maryland joine. Ir than "natural", or Items 23s or 28s-f show Itte Modoal Exama her mout be incitified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Worvorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No II Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 🛣 No	spanic Origin? (Sp n, Mexican, Puerto Specify:		14. Rac	ce - America ck, White, e	an Indian,
Baltimore, Maryland 21215-0036	within 72 hou ene. than "natura the Mcdical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done o DO NOT use retired,	ation turing most of work	king	16b. Kind of B	usiness/Ind	ustry
nd 2	be filed tal Hygie d other event, III	e	17. Father's Name (First, Middle, Last)	sec	cretary		ne (First, Middle, M	Maiden Sumar		
ıryla	s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othe other traumatic event,	To	Anthony Spinnato 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a		s (unknov		, State, Zip	Code)
», Ma	1 and 2 : Health ar tem 27 is		Ray Rollins/son	3036	East Ave	. Park	ville, M	2123	34	
more	0 0		I MADUIA Z CHEMATON 3 LINEMOVALION STATE		sition (Name of matory or other place art of Jesi	L L	1	20c. Location Raltit	·	
Sacred Heart of Jesus C July 29,2008 *4 Donation 5 Other (Specify) 21. Signature of Fineral Service Licensee **John 0 Mitchell IV, Funeral 200 E. Padonia Rd. Timoni										
8760,	death certificate be executed American and deathending physician and deathending burial-transit	icai Examiner	23a. 741. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence con	ence of):						Interval Between Onset and Death
.O. Box 68	that the death certifice and by the attending ph detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year		
Δ.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resu		nderlying cause give			pacco use con	itribute to th	e cause of death?
of Vital Records,	The ate h page	Completed	depression, cors	ring	arten	de con	24a. Was a autops perform	y ned2	Were autor prior to con death? 1 \(\text{Yes} \)	osy findings available inpletion of cause of
Division of Vita	I or Attending Physicien: I after death. Director: After this certification by the funeral director, p	ertification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Actival 5 Pending investigation 3 Suicide 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At hor building, etc. (Specify, Day Page)		f 28c. Injury Work M 1 🗀 \	er: 4 Nursing H	th (Check only only only only only only only only	ence 6 Otto	rred	
_	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edicai Ce	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my know 2 Medicel Exeminer: On the basis of examination and manner stated.	rledge, death ion and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the corred at the time, d	ause(s) and m ate and place,	anner as st , and due to	ated. the cause(s)
)	То th withir To th сопр	Me	29b. Signature and title of certifier Mossler WTULS or	0	29c. License			9d. Date signe		
	2		30. Name and address of person who completed cause of death (Item Matthew Marks Jan	1100	Print)	tern 1	ve, B	alten	are	2009 MD 2 (224
186	Sta Registr		31. Date filed (Month, Day, Year) JUL 3 0 2008	H A	South				· · · ·	

DHMH 17 Rev 1/2001

Angelina

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 1:39PM JAMES ROBINSON /Medical 4c. County of Death **Examiner** 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. 1 XM 2 ☐ F Director 213-26-6328 1, 76 ΜD FEB. 1932 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 ☐ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 N. MONTFORD AVE. 21231 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 □Yes 2 No þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9TH CHAUFFER ICE COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA THOMAS/FRIEND 23 N. MONTFORD AVE., BALTIMORE, MD 21231 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 5712 O DONNELL ST. 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/06/2008 BALTIMORE, MD MT. CARMEL 21224 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service License 2007-09 EASTERN AVE., BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Lesaszlesati /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami attending physician and for use as the burial-trai Due to (or as a consequence of): Box 68760 requires that the death certificate be Physician/Medical 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No o 9 T Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician; The perform Vital 2 🗆 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. within 2 To the 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 1/2001

State

25

32. Segistrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** 815 PM ETHEL MAE RIZER JULY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death FOUNDER ROW 15917 NW MT. SAVALE ALLEGAN Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours Director 218-30-0310 MARYLAND JULY 15 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Provided Examiner must be notified at 1 Yes 2 □ No Director MD ALLEGANY MT. SAVAGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with USA FOUNDRY Row Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No ģ Specify: WHITE 3 ₩Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RECORNS BOOKKEEPER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hi Important: If Item 27 Is marked oth any Injury or other traumattic event once. DAVID JOHD WILLIAMS MARLARET LOUISE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JERRIE HOFF/DAULHTER DRIVE NORTH POTOMAC MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State realister Strongh | 800C, 96 Put Strang STAM SHOTANA 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
ANATOMY GVETS DEGISTRY 21. Signature of Funeral Service Licensee 7522 CONNELLEY DRIVE STEP SULVENAM MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ca /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed and-tran Due to (or as a consequence of) physician a s the burial-Box 68760, Physician/Medical as attending properties for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed certificate 1 ☐ Yes 2 ☑ No Division of Vital 1 □Yes 2 ☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Injury 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 8 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and address of

Bevery

31. Date filed (Month, Day, Year)

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ORIGINAL

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person who completed cause of death (Item 23a) (Type-Frint)

32. gistrar's Signature

500 memorial Ave

Calkins M.D

JUL 3 0

July 23

cumberland mb

2008

08-05653 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Aaron Ridgeway 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day July 23, 2008 **Medical Examiner** aron 0 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Baltimore Johns Hopkins Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 19-52-3418 8 2 F Usual Residence of Decedent 10b. County 10c. City, Town or Location with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Yes Yes 2 No specify: Divorced If Yes. Give Year þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) be filed within 72 tem 27 is marked other than traumatic event, the Medical Baltimore, MD 21215-0036 of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last lores Be ဥ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address 519 N. Vatterson PK 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Cremation 3 Removal from State -3108 5 21. Signat reh Physician List only one cause on each line /Medical Immediate Cause (Final disease -xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed AMENDED 23a, 27, perME, g882 8/8/08 TT the attending physician ed for use as the burial -X UNPENDED IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify)

14. Race - American Indian, Black, White, etc. Specify 16b. Kind of Business/Industry aundry 18.Mother's Name (First, Middle, Maiden Surname) (Street and Number or Rural Route Number; City or Town, State, Zip Code) Approximate Interval lefule disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Hypertensive atherosclerotic cardiovascular disease Physician/Medical 23d. Date of delivery Year Month Day 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Otherexaminer? Hospital: Nursing Home 5 DOA Inpatient 2 V ER/Outpatient 3 Residence 6 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. July 24, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

24508

3. Time of Death

1721 hrs

10d. Inside City Limits

2008

NIA

Country)

Foreian

Division of Vital Records, P.O. Box 68760 this certificate has the Hospital or Attending Physician: hin 24 hours after death. Director:

Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 7:39 Beverly Aletha July 26, 2008 Jane Reddick /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 57 Walden Mill Way Baltimore Catonsville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) Days Hours Min 1 M 2X F Director 53 03-21-1955 226-86-8591 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 200No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 57 Walden Mill Way 21228 by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married African Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. 3 ☐ Widowed 4 ☑ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Administrative Assistant Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oliver M. King Rosemary Summers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lakisha C. Jett - Daughter 2727 South Quincy St., #921, Arlington, VA 22206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages to Department of Himportant: If Ite any Injury or ot August 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) Meadowridge Mem. Pk. 2008 Elkridge, Maryland 21. Signature Funeral Service Licens 22. Name and Address of Facility M00053 Gary L. Kaufman Funeral Home at MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) IDIOPATHIC PULMOVARY Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1☐ Yes 2☐ No death? 1 ☐ Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 🖟 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Some MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

C.VERGARA - SOAPES

31. Date filed (Month, Day, Year)

9940

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 24510 State of Maryland / Department of Health and Mental Hygien 2008 Certificate of Death 2. Date of Death
Month
July 16, Decedent's Name (First, Middle, Last) 3. Time of Death Day 2008 5:50 PMM Irvin A. Smith 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fairfield Nursing Home Crownsville Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1XM 2□ F 220-16-4231 86 1921 Sept 6, Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2√ No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 616 Admiral Drive #351 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No white Specify: Specify: 3 Widowed 4 Divorced

Funeral Director

Physician

/Medical

Examiner

10a. State

Direct

leted by Funeral

MD

11. Marital Status

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, "the Medical Eachth and must be mailted at

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

15. Decedent (Specify only highes		16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking 16b.	16b. Kind of Business/Industry								
15. Decedent (Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired) marina operator										
			ame (First, Middle, Maid	en Sumame)								
Alonzo I. Smit	•		Lie Finkle	-								
19a. Informant's Name/Relationsh	iip (Type, Print)	19b. Mailing Address (Street and Number or I	Rural Route Number, City	y or Town, State,	Zip Code)							
Irma Smith/s	pouse	518 Ridgeley Road (Crownsville,	MD 210	32							
20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 ☑ Donation 5 □ Other (Sp	3 □Removal from State	Place of Disposition (Name of semetery, crematory or other place)	Date 20c.	Location - City or	Town, State							
21. Signature of Funeral Service L Ronal d'S	Baltimore, Mb 21201											
23a. P. 11. Enter the riseas or shull, or heart failure. List of Immediat Cause (Final disease or condition	mplications that caused the deat only one cause on each line.	n. Do not enter the mode of dying, such as cardi	ac or respiratory arrest.		Approximate Interval Between Onset and Death							
resulting in death)	Due to (or as a conseq				1 0 0 1							
Sequentially list conditions.	b. A1+	ered Mental Stat	25									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	venta										
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												
	L _a											
IS SERVALE.												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of descriptions	Il death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year								
Part II. Other significant conditio	ns contributing to death but not res	ulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?							
CA	0		1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknow							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditio	7F		24a. Was an autopsy performed	? death?	utopsy findings availat completion of cause o							
25. Was case referred to medical	1 10	26. Place of D	eath (Check only one)	110								
examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Spe	ecify)							
27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of Injury (Month, Day Year) ation	28b. Time of Injury at Work? M 1 Yes 2 No	28d. Describe how in									
27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide	oot be ned 28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, factory, office (y)	28f. Location (Street City or Town, St	and Number or R ate)	ural Route Number,							
29a. Certifier 1 Certifying	g Physician: To the best of my kno Examiner: On the basis of examina and manner stated.	owledge, death occurred at the time, date and pla ation and/or investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)							
29b. Signature and title of certifier	100-MD Direc	tortain 19c lightse number	29d.	Date signed (Mon	th. Day, Year)							

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death [Item 232] (T, e, Prin 10

31. Date filed (Month, Day, Year)

08-05288

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Don Sherman State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 9, 2008 2110 hrs **Medical Examiner** Don Sherman 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** CSX Tracks at BAK Milemarker 83 Middle River 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Davs Hours Director 40 Nov 1, 1967 CountryMaryland 1^X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2X No MD Middle River 28a-f show Baltimore Examiner must be notified at once. with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9610 Conmar Road 21220 USA 3 23a or Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nodeath 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes f Yes, Give Year Yes 2 X No specify: Specify: white 3 Widowed 4 Divorced "natural" è permit. Pages I and 2 should be filed within 72 hours: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura injury or other traumantic event, the Medical Examing. 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 home improvements 0 window installer 9 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Tew Johnny Sherman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9610 Conmar Road Middle River, MD Rose Shupe/aunt 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 Removal from State Donation & X Other Specify: in state 21. Sunature of Euneral Service Licensee Ronal S. Ware J Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21201 Baltimore MD Approximate Interval rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death Multiple injuries Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED 23a,27,28a-f, perME, g881 7/31/08 TT XUNPENDED signed by the attending physician be detached for use as the burial The law requires that the death certificate be Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>8</u> 1 Yes 2 V No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? ✓ Yes 2 No certificate 1 🗸 Yes 26.Place of Death (Check only one) Division of Vital 25. Was case referred to medical director, Be Otherexaminer? Hospital: ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 1 V Yes မှ 28d. Describe how injury occurred Subject structory train after lying on funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 1 Natural 1 Yes 2 X No Pending 7/9/08 FNd 8:50 pm the railroad tracks 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town State) CSX ETACKS (BAK 3 X Suicide Could not be orTown, State) CSX tracks @ BAK Milemarker 83 Middle River, MD determined railroad 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certific

30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 10, 2008

31. Date filed (Month, Day, Year) State Registra

29b. Signature and title of certifier

nu

32 Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 21 per dvr g884 10-10-08 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month SUC AM **Physician** Baby Girl Simon /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year)
July 17, 2008 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 3 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 4 1 □ M 2 🗓 F Maryland **Director** infant Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at MD 1√∑ Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? death with 2727 Pelham Avenue 21213 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any linuy or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: black \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be Alicia Simon မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🕅 Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street per dvr 21201 Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Promaturit Extreme **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Tectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u>გ</u> 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No Yes Yes 2 🗌 No 1 Tes certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 No 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury 1 Yes 2 No s after death. 2 Accident by the 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Spec/fy) 4 - Homicide filled in 24 hours to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Funel

completely fi Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

RES -000 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JUL 3

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

0

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Scott Sul 0615 Laudia 2009 15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 6 spital Balymore If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8-13-4 9. Birthplace (State or Foreign Country)
MARYLAND **Funeral** Days Months 1 □ M 2 🗗 F 8 216-50-462 5 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Balt more Md Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Kound 21225 death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Item 1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 3altimore, Maryland 21215-0036 Specify: Black Completed by 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Analys Loans 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAME 2 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Pytht) 35 24 Kound Balto, Md. Daughter JANICE Scott 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3-Removal from State 29 priew Crematory 0 5 ☐ Other Specify 4 Donation 22. Name and Address of Facility 21. Signature of Funeral Se KU Heres Metropoldan chapel BROADWA 1639 Baito. rt1. Enter We disease hock, or heart failure. e. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respil atory arrest, ist only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician Failuce Acute Reval disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner borach Cancel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or se a consequence of) Examiner Aremia attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Month Day 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **X** No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ို 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of Certifier 29d. Date signed (Month, Day, Year) Sohoib Mohiuddin 30. Name and address of person who con pleted cause of death (Item 23a) (Type, Print) Mohio Harbor Bultinog MA 3001 Soharb 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 24514

Benjamin Alden S		rin State	of Maryland /			t Healtr f Death	and Menta	ai nygiei	Reg. N	0.	
Physiciar	R	egistrar . Decedent's Name (First, Middle,Last)					2. Date	e of Death		3. Time of Death 1001 hrs
Medical Examin	er		BENJAM	IN AL	DEN			July	nth Day 723, 2008	4c. County of Dea	
	4	a. Facility Name (if not institution, give	street and number)			4b. City, To	wn, or Location of ore	Death		City	
		University Hospital Social Security Number 6. Se	v 7 Age	e (In yrs. last	birthday)	If Under		24Hrs. 8. Da	ate of Birth (N	IM/DD/YYYY) 9. B	irthplace (State or Foreign
Funeral Director	ľ	04 5 4 7 2022	M 2 F	20		Months		Min.	0/29/		ARYLAND
y.		Usual Residence of Decedent Oa. State 10b. County		10c. City, To	own or Loca	ation					10d. Inside City Limits
ow any		MD CARR	OT.T.	WES	מדאת	ISTER					1 Yes 2 X No
rylanc la-f sh	황	Oe. Street and Number	0111	,,,,,,,,		10f. Zip (Code		10g.	Citizen of What Co	untry?
he Ma 1 or 28	Director	2501 OLD TANK	EYTOWN R	D.			158			USA	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int. If licm 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1. Marital Status 1 X Never Married 2 Married	12. Was Decedent Armed Forces? 1 Yes 2		. 13. V	/as Deceden Yes, specify	t of Hispanic Orig Cuban, Mexican,	in? (Specify) Puerto Rican	res or No- , etc.)	White, etc.	
fter de		3 Widowed 4 Divorced	If Yes, Give Year				X No specify:			Specify: WH	
136 hin 72 hours after than "natural", edical Examiner	핡	15. Decedent's Education (Specify o	nly highest grade cor		16a. Deced	ent's Usual C most of work	occupation (Give ling life, DO NOT	kind of work de use retired)	one 16	b. Kind of Busines	s/industry
6 172 h an "n ical E	<u></u>	Elementary/Secondary (0-12)	College (1-4 or 2	5+)	MEC	TNAHT	CAL DES	STGNER		MANUFAC	CTURING
5-0036 lied within 72 hours after Hygiene. 1 other than "natural"; the Medical Examiner	Completed	17. Father's Name (First, Middle, Last		l						den Surname)	
215- be filed ntal Hyg rked of	BeC		Y IRA SC	CHRI	N					CHMANN	
212 ould bould b	ᆰ	19a. Informant's Name/Relationship (Гуре, Print)			ing Address					ate, Zip Code)21158
MD and 2 sho alth and m 27 is		JAY I. SOCHRIN	- FATH	IER			TANEYI ne of cemetery,	COWN R	RD., WE	STMINS Oc. Location - City	rER, MD
re, s I am ff Heal If iten	Ì	20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from S	tate Cr	rematory or	other place)					
Page nent of ant:		4 Donation 5 Other Specifi	<i>t</i> :	KRI			METERY				STER, MD
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Importants If item 27 is marked other thingury or other traumatic event, the Med		2 Signature of Funeral Service Lice	nsee								HOME, P.A. MD 21157
	-	23a. Part I Enter the disease, or com	plications that cause	d the death.	Do not ente	or the mode of	of dying, such as o	cardiac or resp	oiratory arrest	, shock, or heart	Approximate Interval Between Onset and
Physician 'Medical		failure. List only one cause on e	ach line. Multiple Blunt I								Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con-								
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	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence or	1.						
1	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of	f):						
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O, be ex	ledical	UNPENDED	AMENDED		na nav					23d. Date of del	ivery
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate thin 24 hours after death. In Fineral Director: After this certificate has been signed by the attending physympletcy filled in by the funeral director, page 2 should be detached for use as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	ome or pregi	2	Fetal death	3 Ectop	ic pregnancy		Month	Day Year
X 6. th certification arruse a	sicia	1 Yes 2 No 9 Unknow		at time of de	ath 5	Other (Spe	cify)				
ords, P.O. Box 6876 w requires that the death certificate s been signed by the attending phy should be detached for use as the	Physician/N	Part II. Other significant conditions		ath but not re	esulting in t	he underlyin	g cause given in F	Part I.	23e. Did tob	acco use contribut	te to the cause of death?
P.O.	ģ	Fait II. Other significant condition	o contained any to be						1 Yes	2 🗸 No 3	Probably 4 Unknown
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Records, The law requir ficate has been 8	nple								perform	ned? dea	
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ital sician is certi	Be	examiner?	Hospital: 1 / Inpa	itient 2	ER/Outpa	tient 3	DOA Other	Nursing H	ome 5 F	Residence 6	Other:
Division of Vital rat or Attending Physician: us after death. al Director: After this certifled in by the funeral director	년 -	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of I (Month, Da Jul 22, 200		28b. Time		28c. Injury at Wo	ork? 280	d. Describe h	ow injury occurred cycle auto col	lision
On cendin ath.	tion	1 Natural 5 Pending 2 ✓ Accident Investig	-41		2156 hrs		1Yes 2	No			
ViSi or Att fter de Directi in by	ifica	2 ✓ Accident Investig 3 Suicide 6 Could n	28e Place of	f Injury - At h	nome, farm,	street, factor	y, office building,	etc. 28	f. Location (S or Town, St	treet and Number (ate)	or Rural Route Number, City op Road, Westminster, M
Divinital of ours a curs a curs a filled	Certification:	4 Homicide determi	1 1 1 1								
Division To the Hospital or Attend within 24 hours after death or the Funeral Director: completely filled in by the 1		29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	ician: To the best of	f my knowled examination a	dge, death o and/or inves	occurred at the stigation, in r	ie time, date and j ny opinion, death	place, and du occurred at th	e to the cause e time, date a	and place, and due	to the cause(s)
To th within To th	Medical	29b. Signature and title of certifier	and manner state	ed.			9c. License numb				(Month, Day, Year)
	~	255. Signature and time of certifier	1.		MD		O.C.M.E.			July 25, 200	8
		30. Name and address of person w	no com teto cause	of death (Iter							
8		Russell Alexander MD.	Assistant Me	dical Exa	miner	111 Penn	Street, Baltin	more, MD	21201		
	tat		32. Regis	strar's Signa	ture					OCME	
Regis			2008 /40		K	Books				W 41115	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 2008 1630 July 27 Herman Fred Shermer, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Georges 14223 Summit Lane Laurel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2 □ F Yrs May 6. 1952 Director Washington DC 220-56-6301 56 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ima Medical Executions in the insulfactor. 1 ☐ Yes 2 No Director Maryland Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14223 Summit Lane 20708 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ≥ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Linguist U.S. Govt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Betty Jo Smalley Herman Fred Shermer, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sue Ellen Seevers- Sister 1812 Conewago Lane, Lancaster, PA 17601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/30/2008 Atlantic Crematory Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fleck Funeral Home, INC. MO1234 Maryland 20707 7601 Sandy Spring Rd., Laurel, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Arrhythmia resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Disease 5 vears Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner be executed pate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) Month Year Day 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Wegeners Granuiomatosis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 1 Yes I or Attending Physician: Taffer death.
Director: After this certifica filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) completely within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title MDJuly 29, 2008 D58747

State Registrar

DHMH 17 Rev 1/2001

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ORIGINAL

10700 Charter Drive Suite 200, Columbia, Maryland 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. pgistrar's Signature

Riesett.

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Evaminar must be notified at aging.

Baltimore, Maryland 21215-0036 Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Regist

•	1 - State Registrar		Certificate of Death Reg. No.					J 24010		
	1. Decedent's Name (First, Middle, Las	st)				2. Date of Deat Month		3. Time of Death		
an al	Thelma	Lois	Saxton			July 22	, 2008 Year	2:35 PM		
er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Deat	h	4c. County of Dea	th		
	Gilchrist Center				imore			imore		
	5. Social Security Number 6. S	ex 7. Age (li	n yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) Co	thplace (State or Foreign ountry)		
	178-10-9284		94 Yrs.			12-16-	1913 Per	nsylvania		
	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	.ocation				10d. Inside City Limits		
ō	MD Balt	imore		White Mar	ah			1 □Yes 2 🔯 No		
rec	10e. Street and Number	IIIOLE	_	10f. Zip Code	.511	1	0g. Citizen of What Co	ountry?		
Ö	11208 Beach Road			2	1162		United States			
era	11. Marital Status	12. Was Decedent Eve	r in U.S. 13	Was Decedent of Hi	ispanic Origin? (9	Specify Yes or No-	14. Race - Am-	erican Indian,		
Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □ Yes 2X No		If Yes, specify Cuba		to Rican, etc.)	Black, Whit	ie, etc.		
by	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2XDNNo	Specify:		Specify:	White		
Be Completed by Funeral Director	15. Decedent's Ed	Jucation	16a. Dec	edent's Usual Occupa re kind of work done d	ation furing most of wo	rking I	16b. Kind of Business	/Industry		
nple	Elementary/Secondary (0-12)	College (1-4or 5+)	· life.	DO NOT use retired,	")		_			
ပ္ပ	12			Homemak		me (First, Middle, i		Home		
	17. Father's Name (First, Middle, Last)	,					vialuen Gumame)			
2	Frank Shannon		1.0. 11.			Baker	r, City or Town, State,	Zin Cada)		
	19a. Informant's Name/Relationship (-								
-	Susan E. Krause		20b Place of Disc	position (Name of		Date 1LY	e, MD 2120 20c. Location - City of			
	1 🖾 Burial 2 ☐ Cremation 3 ☐			ematory or other place	1	-	Ellessi des	Masser I am d		
	4 □ Donation 5 □ Other (Specifical Service Liber 1997)			idge Mem. 22. Name and Addres		, 2008		<u>Maryland</u> eral Home at		
	Nach 13	nsee) M0005	2		GC	,	ridge, MD			
	23a. Part 1. Enter the disease, or com	plications that caused the						Approximate		
	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	21152-5					Interval Between Onset and Death		
	disease or condition resulting in death)	a. Due to (o) as a c	consequence of).					weeks		
		Due to (or as a c	onsequence or,							
ř	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a c	onsequence of):							
Ē	Cause (Disease or injury that initiated events	C								
EX	resulting in death) Last	Due to (or as a c	onsequence of):							
Medical Examiner		d								
Wed	IF FEMALE:	-			77:0			3 170 1 100		
	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 [B Ctopic pregnanc	y		23d. Date of d Month	elivery Day Year		
sici	1 □ Yes 2 No 9 □ Unknown	4 ☐ Pregnant at tir 9 ☐ Unknown	me of death 5	5 ☐ Other (specify)				,		
Be Completed by Physician	Part II. Other significant conditions of	contributing to death but a	not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?		
by		mall Box	WOGS	MEDIO	2	1 🗆 Y	res 2. 1 No 3 □	Probably 4 🗌 Unknown		
eted	30/3/3/		(0 0 0	0-1.0	3		7	autopsy findings available		
dr.						24a. Was autop	sy prior to	completion of cause of		
S						1 □Yes	2 1 □ Ye			
	25. Was case referred to medical examiner?	Hospital:		Oth	er	eath (Check only o	10			
F.	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient	28b. Time	ient 3 DOA	4 L Nursing	Home 5 Resid	dence 6 Other (Sp now injury occurred	becity) (VU+SPUG-		
tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Y	<i>(ear)</i> Injury		ḱ? Yes 2 □ No					
fica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury	- At home, farm,	street, factory, office			Street and Number or	Rural Route Number,		
erti	4 Homicide	building, etc.	(Ѕресіту)			City or Tow	vn, State)			
Medical Certification: To	29a. Certifier 1 Gertifying P	hysician: To the best of miner: On the basis of e	my knowledge, de	eath occurred at the ti	me, date and pla	ce, and due to the	cause(s) and manner	as stated.		
edic	(Check only 2 Medical Exa	and manner state		mivesugation, in my c						
Σ	29b. Signature and title of certifier	A 1400		29c. Licens	29d. Date signed (Mo	ntn, Day, Year)				
	Alexan	(VVV)		195	050.	>	TUCH JT	2006		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								110 2 12 5-1		
	AAUN J.C	HAMURES.	s Signature	0/01/V	CHU	LUES ST	JONSUN	NO 21204		
ate rar	31. Date filed (Month Pay Year) 20	108 Registrary	s Signature	carles						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 27 Day **Physician** ĴÜĽΥ 2008 1:59A STARK ALEXANDER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON Birthplace (State or Foreign Country) MD If Under 1 Year | If Under 24 Hrs. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 017177 1910 1**X** M 2□ F 98 212-03-5712 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the wholical Examinar must be notified at 1 ☐ Yes 2 X No BALTIMORE TIMONIUM **Funeral Directo** MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21093 USÁ 2117 SWEETBRIAR LANE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 1 ☐ Never Married 2 X Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. <u>ک</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE REAL ESTATE AGENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be REBECCA STARK JOSEPH 1 4 1 ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any Injury or other trau PAULINE STARK / WIFE 2117 SWEETBRIAR LANE, TIMONIUM, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of campitary, cramatory or other place)
MEMORIAL PARK Date 20a. Method of Disposition 1X Burial 2 Cremation 3 Remayal from State RANDALLSTOWN, MD 07/29/2008 4☐Donation 5☐Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final an **Physician** scheme disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Tria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed noxina and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) ed by the a detached f 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 □Yes 2 No page 2 or Attending Physician: The 1 ☐Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 □Yes 2 □ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2008 rear July 28, 9:58 AM Rhonda Shiflett /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-18-1956 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 □ ¥ 52 **Director** 216-62-9662 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show marked other than "natural", or items 23a or 28a-f shov umatic event, in the dical Evantur must be myllhed in Director 1 1 Yes 2 □ No Dundalk Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 1922 Denbury Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dental 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be fi Mary Ellen Williams James Wolf Important: If item 27 is marked any injury or other traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1922 Denbury Dr., Dundalk, MD 21222 Robert Shiflett - Husband Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 Acremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-29-08 Baltimore, MD Bayview Crematory 22. Name and Address of Facility 21. Signature of Eupo Bradley-Ashton Funeral Home 2134 Willow Spring Road, 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that cause 1 ie death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in . Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consequence of Exami Due to (or as a consequence of) physician the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2 No 9 Unknown o 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been s page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nerforme certificate 1 □ Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6-Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital or 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUL 2008 DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygien 2008 24

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 800 A LAWRENCE PATRICK 300 TAYLOR 97 Soog /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ATLANTIC GENERAL HOSPITAL 切印アこと WORCESTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Sex 1M 2□F Days 310.43 637 Director DECEMBERG 1951 PENNSTLUANIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No MI Director WORCESTER SNOWHILL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 21811 USA SOUTH CHURCH STRUET 301 Funeral or itama; 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If them 27 is marked other than "nu any njury or other treumatic event, fire Media once. Elementary/Secondary (0-12) College (1-4or 5+) AN ENFORCEMENT POLICE OFFICER 19 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DIETRICH EDWARD TAYLOR EDITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AT, 103, SNOWHILL MS ELEANOR TAYLOR /WIFE 301 SOUTH CHUTCH ST. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ANOTOMY GIFTS DECISTRY JULY 30, 2008 MANDUAR, MARYLAND 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
ANATOMY CIFTS PLECISTRY
7532 COUNTILEY DR. STEP, HANDUIS, NO 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician hranic obstructive pulmomary diseas /Medical Examiner obacco Abrus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Records, lin dependent Dispetes Melitels. 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an Bleedin autopsy performed? Yes 2 No 21 No 1 Yes Vital 1 Yes or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 🗌 Yes Division of After this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 Yes 2 No To the Hospitel or Attendi within 24 hours after death.
To the Funeral Director; A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JULY 28, 2008 30. Name and address of person who completed cause of death (Item 23a) (Troe, Print)

GRANAWadan, MD 9714 Healthway Drive Berton, MD 21811 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

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Lawrence

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . ^{Day} 2008 July 26, DOROTHY 5:54 p м Ε. TIMMONS 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey House N/A Baltimore 9. Birthplace (State or Foreign Country) Pennsylvania If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 09 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 09,1914 220-07-6293 94 Hours Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No N/A Maryland **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 802 Washington Blvd. 21230 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 🛣 No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Raleigh Clothes Garment Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unkown Unkown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Sloan 509 Wyeth Street, Baltimore, Maryland 21230 (Friend) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Mem. Park 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-30-08 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility Cully-Polyniak Funeral Home P.A. O East Fort Avenue, Baltimore, Maryland 21230 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final WEEKS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performs 2 No 1 ☐Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Physician/Medical Completed Be

Examiner sician and burlal-trans attending physician for use as the burla signed by t I be detach page 2 should funeral director, Certification: To filled in by

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be mailing at

Il Hygiene.

Department of Health a Important: If item 27 is any Injury or other traigne.

Physician

/Medical

Examiner

Pages '

Baltimore, Maryland 21215-0036

Deroth

5:54

68760,

P.O. Records, Vital ō To the Hospital or Attending within 24 hours after death. To the Funeral Director; After Division

State

29b. Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of pe

31. Date filed (Month, Day

29a. Certifier

(Check only one)

Medical

Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 08 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Monti **Physician** Year /Medical 4a. Facility Name (If not institution, give street and number Cherry Lane Nursing Center 4b. City, Town, or Location of Death 40 Examiner County of Death Prince George 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 23, 1924 Birthplace (State or Foreign Country) New York 5. Social Security Number **Funeral** 1□M 2፟ØF Months Days Hours 86 Yrs Director 132-20-1989 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ritems 23a or 28a-f sh 1 ☐ Yes 2 No Director Laurel Maryland Prince George 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9110 Montpelier Drive 20708 LISA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🐧 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2XNo White Specify: other traumatic event, the Medical Ever ģ Specify: 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 5+^{College (1-4or 5+)} Elementary/Secondary (0-12) **Organist** Church 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Alfonso Aliberto Antoinette Dimatteo ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Tedeschi - Husband 9110 Montpelier Drive, Laurel, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's of the Mills
Church Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 07/23/2008 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Fleck Funeral Home, Inc. WOIZ8 3 7601 Sandy Spring Road, Laurel, Maryland 20707 Part 1. Inter the diseare, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Inter the disease, Approximate Interval Between Onset and Eggi Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Just the as a consumerous A Exami and burial-tran Due to (or as a consequence of): Box 68760, attending physician certificate be Physiclan/Medical the as nse yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery for 1 3 ☐ Ectopic pregnancy Month Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) ned by the a detached f P.0. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 ☐ Yes 2 1 ☐ Yes 2º ☐ No Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Mann of Death After t 28b. Time of 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation within 24 hours after death. To the Funeral Director: A 1 □Yes 2 🗆 No 2 ☐ Accident filled in by the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical and manner stated person who completed cause of death (Item 23a) (Type, Print) Warre 82. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 3 0 Registrar

State of Maryland / Department of Health and Mental Hygiene **Edward Triplett** Certificate of Death 1- For State Registrar Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Day Month Day July 13, 2008 0430 hrs **Medical Examiner** Edward R. Triplett 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Union Memorial Hospital **Baltimore City** 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Davs MD Director 215-84-4567 42 12-20-1965 $_{1}$ \mathbf{X}_{M} 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State Yes 2 No Baltimore City 28a-f shov MD notified at once, with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 326 S. Lehigh Street 21224 USA 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married hours after death Married Yes Specify: White Yes 2 X No specify: If Yes. Give Year Divorced 3 Widowed is marked other than "natural", atic event, the Medical Examiner ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) permit, Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 12 Construction Worker Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Milton R. Triplett Mary C. Bavis Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 326 S. Lehigh St., Baltimore, MD 21224 Mary Witomski - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Removal from State 2 XCremation 3 Bayview Crematory 7-24-08 Baltimore, MD Other Specify 21. Signature of Fun Bradley-Ashton Funeral Home complications that caused the death. Do not enter the mode of dying, such as card proximate Interval 23a. Part I. Enter the disease, or Physician Between Onset and failure. List only one cause on each line. Death /Medical a. Heroin and Cocaine Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The aw requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and ted for use as the burial - transit Physician/Medical AMENDED UNPENDED Division of Vital Fecords, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ò Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes certifi ate i ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medica Be Other₄ examiner? Hospital: 1 Residence 6 Other ER/Outpatient 3 V DOA Nursing Home 5 Inpatient 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Unnknown FOUND: Natural 1 Yes 2 ✔ No Pending the 0342 hrs Jul 13, 2008 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Found, 1700blk. Latrobe St., Baltimore City, Md Suicide determined (Specify) Local Street Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 13, 2008 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 31. Date filed (Month, Day Year) 32 Registrar's Signature State 2008 Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g881 Of 129 08 dab eath Reg. No. 24524 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Alfred Frederick Upman, Jr. 0230M Uly 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Randallstown Seasons Hospice at Northwest Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Min Months Days Hours MD 47 214-84-1367 Jan 2, 1961 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD **Baltimore** Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 1935 Old Frderick Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Forklift Operator Warehouse 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Beulah Connie Ringley

MD

REISTERSTOWN

20c. Location - City or Town, State

Marriottsville, Maryland

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Jul 11, 2008

1935 Old Frderick Rd. Catonsville, MD 21228

Slack Funeral Home, P.A.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in. Walter Examiner must be notified at any injury or other traumatic event, in. Walter Examiner must be notified at Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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19a. Informant's Name/Relationship (Type. Print)

1 Burial 2 ☐ Cremation 3 ☐ Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Alfred F. Upman, Sr.

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Jery ce Liouise

20a Method of Disposition

Funeral

Director

Physician /Medical Examiner

nours after death.

neral Director: /

Hospital or Attending Physician: The law requires that the death certificate be executed

 $\beta\beta\alpha$ Division of Vital Records, P.O. Box 68760,

	Muladillache	DIGHT MOIZGE	3	Slack Funeral Home 3871 Old Columbia F	, P.A. Pike Ellicott City,	MD 21043	
_	23a. Part 1 Enter the dispase, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as a construence of Medical Renal)	Renal on: L Disea	Failure	c or respiratory arrest,		Approximate Interval Between Onset and Death
Physician/Medical Examiner	if any leading to miniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	Nephro	oathy			
ysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopi 5 ☐ Other	c pregnancy (specify)		23d. Date of de Month	slivery Day Year
ed by Pr	Part II. Other significant conditions co		ibute to the cause of death? 3 ☐ Probably 4 ☑ Unknown				
Completed by					24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3	10"	ath (Check only one) Home 5 Residence	6 ☑Other (Spe	ecify) SEPLSONS E
ation:	27. Manner of Death 1		ime of njury M	28c. Injury at Work? 1 ☐Yes 2 ☐No	28d. Describe how in		
Medical Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, fact	ory, office	28f. Location (Street City or Town, Sta	and Number or R ate)	ural Route Number,
edical	29a. Certifier 1	/slcian: To the best of my knowledge iner: On the basis of examination an and manner stated.	, death occurr d/or investigat	ed at the time, date and plaction, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner a and place, and du	s stated. e to the cause(s)
M	29b. Signature and title of certifier	w		29c. License number 144593 /		Date signed (Mon	

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Memorial Gardens

22. Name and Address of Facility

Alfred Frederick Upman Sr.

DHMH 17 Rev 1/2001

State Registrar

within 24 hor To the Fune completely fi

25 MAIN STREET

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary	•	rtificate of		nemai nyg R	leg. No. 200	8 24525				
ja.	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Yea	3. Time of Death				
	/Medic	al	Willard Eugene		:	4h Oihi Taum	r Location of Death	07-	21 - 0 8 4c. County of De	3: DO A M				
7	Examin	er	4a. Facility Name (If not institution, give s Coastal Hospice		Lape		SBURY			ouico				
عدت.	Funeral Director		5. Social Security Number 6. Sex 216–36–2257		o yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day June 28		Sirthplace (State or Foreign Country) aryland				
	w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits				
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	th the or 28a e nott	irec	10e. Street and Number	I		10f. Zip Code		1	10g. Citizen of What	Country?				
	ath wi	ral	300 Broad Street				1811		USA					
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	I2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2ৣK No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Hace - Ar Black, Wi Specify: W					
Maryland 21215-0036	within 72 ho ene. than "natu ne Medical	mpletec	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired SSembler	during most of work	king	16b. Kind of Busines	ss/Industry unk				
d 2	filed Hygie	ပိ	17. Father's Name (First, Middle, Last)	0	а	SSCHOLCI	18. Mother's Nam	e (First, Middle,	Maiden Surname)					
<u>lan</u>	Jid be Jental rked c	To Be	Williard Eugene V	Jarehime Sr	:		Helen B	essie Ba	ker					
	and 2 sho salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Tyg Glena Warehime/sp	ouse	300	Broad Str	and Number or Ru		r, City or Town, State 21811	e, Zip Code)				
Baltimore,	Pages 1 ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☒ Donation 5 ☐ Other (Specify)	, ne	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location - City	or Town, State				
Balt	permit. Depart Import any inj		21. Signature of Euneral Service License ROTIALO	une	Ва	altimore,	MD 2120	1	Baltimore	Street				
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Division or Vital Records,	The law re ate has bee page 2 sho	Completed						24a. Was a autop perfor 1 Yes						
Vita	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	lospital:				th (Check only o	ne)					
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Divis	ai or Atte s after dea al Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury building, etc. (reet, factory, office		28f. Location (S City or Tow		Rural Route Number,				
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C		sician: To the best of n ner: On the basis of ex and manner stated	amination and/or in									
	To the To the Comp	M	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Me					
•			N. S. (C			00	058410		7/21	108				
			30. Name and address of person who co		h (Item 23a) (Type, V HOS PÌC	Print) P.U.	30x 177	3 14	Cic puny	108 mp 51805				
	Sta	te	31. Date filed (Month, Day, Year)	32. Refistrar's			. , , ,	- 3/1	1300	1) 0100				
	Regist	ar	JUL 3 0 2	008	1 K	Page 1.								

DHMH 17 Rev 1/2001

Willard B. Warehime

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Fleath and Mental Hygiene

Certificate of Death

Reg. No. 2008 2. Date of Death Da**2008** Year 1. Decedent's Name (First, Middle, Last) **Physician** 12:00P M Ju₁y Wilkens Dorothy Strehlav /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rosedale Baltimore Manor Care Rossville 8. Date of Birth (Month, Day, Year) 09.05.1914 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 1 M 2 F 93 MD 215.05.1391 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene.
'is marked other than "natural", or items 93a or 98ad other than "natural", or items 93a or 98ad other than "natural". 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventimes, national parts. 1 ☐ Yes 2 No Director Rosedale Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21237 6600 Ridge Road Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No li Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 □Yes 2 🖼 📆 Specify: White Specify. à 3 Swidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marian Ethel Wallis William Thomas Strehlav 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Heatth ar Important: If Item 27 is u any Injury or other traus H Fallen Tree Ct. Baltimore, MD 212 | Sposition (Name of Date | 20c. Location - City or Town, State MD 21227 Kline Patricia Tracy-Lee 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 DeBurial 2 ☐ Cremation 3 ☐ Removal from State 07.30.08 Forest Hill, MD Rock Spring Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, P. 21. Signature of Funeral Service Licenses MO1443 A. 8717 Green Pastures Dr. Balto., MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. demoution Immediate Cause (Final End Physician disease or condition resulting in death) /Medical Due to (or as a conseq I nce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Dav Year for in the past 12 months? Pregnant at time of death 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner2 26. Place of Death (Check only one) Other 45 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Bertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier cause of death (Item 23a) (Type, Print) Ste Ogkwood Rd

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 07-21-2008 Gwendolyn Washington 40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9212 Briarchip St. Laurel PG | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 1 -0 1 -1 9 4 3 9. Birthplace (State or Foreign Country)
Wash DC 5. Social Security Number 7. Age (In yrs. last birthday) 578-56-0054 1 □ M 2X F 64 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County DC Washington 1 ☐ Yes XXNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 817 Delafield Pl. NW 20011 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 XX If Yes, Give Year or Dates: XXNever Married 2 ☐ Married 1 □Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Private Entreprenurer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Macvay Washington Eloise Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dwayne Washington/ Son 2319 St. Clara Dr. Temple Hills, MD 20748 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07-25-2008 Wash. DC Mt. Olivet Ceme. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facilite Ronald Taylor II FH 108 W. North Ave. Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or a consequence of): disease or condition resulting in death) Diabetes (or as a consequence !): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic bronchitis Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 🗆 No 1 ☐Yes 2 XNo 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Dassiteis Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify) 1∕ Yes 2 No

House

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

7-24, 2008

Physician /Medical Examiner

Physician

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

nd Mental Hygiene. marked other than

Health and em 27 is n

permit. Pages 1 and Beatth Department of Health Important: If Item 27 any injury or other troones.

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Expriner must be notified at

/Medical

law requires that the death certificate be executed burial-t attending physician for use as the buria

been signed by the should be detached page director, this funeral After

Physician/Medical Examiner Completed by Be Medical Certification: To

27. Manner of Death

2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Dusan Madonn

5 Pending

investigation 6 ☐ Could not be

determined

ualoma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 68760, o. σ. Division of Vital Records, or Attending Physician: The ospital c. 4 hours after dea.. ral Director; Afte To the Hospital within 24 hours a To the Funeral I completely

State

DHMH 17 Rev 1/2001

Registrar

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Gorman Road Laurel, Maryland

H 59597

1 Yes 2 No

28a. Date of Injury (Month, Day, Year)

8871

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 20:14 M Whiters Louise /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Bay view Medical Citt If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) New york 1 ☐ M 2 🗗 F 213-30-0564 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Balto 1 dYes 2 No Director Ma 10g. Citizen of What Country? 10e. Street and Number USH Funeral [GRUNDE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital/Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT, use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodias gnitor 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Lillie Mae hiters mond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenwad Ave. Whiters Balfe. Melvin son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signal re of Fundal Service Lice 22. Name and Address of Facility Broadwa Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiag or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Find disease or condition resulting in death) Pulscless minute Due to (or as a consequence of): Sepsis

Justo (Fas a consequence of): Weks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 PNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury

Examiner or Attending Physician; The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tra Division or Vital Records, P.O. Box 68760, < within 24 hours after death

To the Funeral Director:
completely filled in by the f

Certification: To

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23 or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

4 ☐ Homicide

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES. 000

29d. Date signed (Month, Day, Year)

State

Medical

Linda 31. Date filed (Month, Day, Year)

32. Registrar's Signature 2008

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Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician CORNELIA Month WICKS 26 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BON SECQUES HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day) . S&it Decurity Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** -230 1 □ M 2 💢 F Months Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 □Yes 2 XNo Director 1d. nmore 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 212 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian. 11, Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. à 3 Widowed 4 □ Divorced Completed traumatic event, the Modical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Work a ctor tore 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P P mina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore Nat'L P. Ke Keith Bacto, md. 21229 Department of Health Important: If item 27 any Injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 31,208 Arbutus 4 □ Donation 5 ☐ Other (Specify) 21. Signature 22. Name and Address of Facility 0 eto, ma complications that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, 23a. Part . F or the disease, or complications that caused the shock in hear failure. List only one cause on each line. Immediated ause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death CEMIA . Physician /Medical Due to (or as a consequence of) PERTENSIVE CARDIOUASCHLAR Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-t ansif FAILURE attending physician and Due to (or as a consequence of): R ARRH Physician/Medical IAC IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 5 ☐ Other (specify) P.O. as been signed by the 2 should be detached 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy page this certificate 1 ☐ Yes 2 17 No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending 1 □Yes 2 □No To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier 00030355 2008 of death (Tem 23a) (Type, Print) BON SECOURS CRUZ M.

Registrar's Signature M. S

Registrar DHMH 17 Rev 1/2001

State

Ypar) 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #7, PerFH G882 8/6/08 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Thomas Francis White 2008 Ju1y 25, 9:24pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice Dove House Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**X** M 2 ☐ F 175-40-1932 Director 57 56 Aug 16, 1951 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f show 1□Yes 2□No Director Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7139 Harlan Lane 21784 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2√ No If Yes, GiveA Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White ≥ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any injury or other traumatic event, the Management on the traumatic event, the Management of the Managemen Elementary/Secondary (0-12) College (1-4or 5+) <u>Roofing Consultant</u> Roofing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Thomas William White Virginia D. Stronsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary A. White (Wife) 7139 Harlan Lane Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 17/29/2008 Sykesville, MO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, P.A. MOO 764 PO Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Of Set and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No. 9 Unknown signed by the best of the signal of the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 perform 1 ☐ Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 DOther (Specify) DOVE HOUSE Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation ours after death. neral Director: A filled in by the fu 1 ☐ Yes 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated 29b. Signalure and title of certific eted cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - For State Registrar Q 2. Date of Death 90 1. Decedent's Name (First, Middle, Last) JULY 28, **Physician** 2008 6:05 AM MARIAN ANNA WAUDBY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GILCHRIST HOSPICE TOWSON 8. Date of Birth (Month, Day, Year)
JULY 3, 1924 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5 Social Security Number 6 Sex 7. Age (In vrs last hirthday **Funeral** Months Days Hours 1 □ M 2 □ XF 217-12-9942 MD 84 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the Medical Evaminer must be notified at 1√2 Yes 2 □ No Director MD BALTIMORE N/A the 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Wandby ö 21206 USA 5914 CEDONIA AVE "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married WHITE Maryland 21215-0036 1 □Yes 2 No Specify þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) IRS CLERICAL SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be fi LAWRENCE HUBER ELIZABETH HAMMERBACHER ပ and 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Important: If item 27 any Injury or other tra 111 SPRING SIDE DR TIMONIUM, MD 21093 NANCY HOOD-DAUGHTER Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 to 1 Deurial 2 Cremation 3 Removal from State PARKWOOD CEMETERY 7/31/08 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Fundamental ervice Licensee 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or reart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** 720/00 disease or condition resulting in death) deli /Medical Due to (or as a con equence of): montas Examiner MEMINTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner and certificate be exect burial-t Due to (or as a consequence of) Box 68760. physician Physician/Medical as the attending IF FEMALE: nse ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify 2 No the a □Yes Ö 9 Unknown signed by t ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? 1 ☐ Yes 2 2 No 1 ☐Yes 2 ☐No or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 \(\tau \) Nursing Home 5 \(\tau \) Residence 6 \(\tau \) Other (Specify) \(\tau \) \(\tau \) (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Certification: Feil Nom (Maring, Landed in Contra-Division 1
Natural 5 ☐ Pending 1030 PM 1 ☐ Yes 2 No after death. death. investigation J14 77 3005 in by the 1 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) S ☐ Suicide determined 4 Homicide Ill springside da, Timonium, mo within 24 hours a home Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHMIES wo 6701 N. Charles 5 Tonson m 21204

DHMH 17 Rev 1/2001

State

Registrar

J

JUL 3

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2008

			Amend Item 20b State of Maryland / for State WCHD/SH 7/21/08 per FH Registrar	Depa Ce	artment of H rtificate of L	ealth a Death	nd Mental Hy	giene 2 0	80	24532
	D:		1. Decedent's Name (First, Middle, Last)				2. Date of De	eath Day	Year	3. Time of Death
	Physicia /Medic		CHARLOTTE MAY BOWMAN				July	1810	1008	11'CJAM
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or				y of Death	
-			WASHINGTON COUNTY HOSPITAL	Linto do A	HA If Under 1 Year	GERST			ASHIN	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🖾 F 7. Age (In yrs. last section 219-66-1592	Yrs.	Months Days	Hours	4 Hrs. 8. Date of Bi (Month, D Jan. 1	8, 1913	9. Birth	place (State or Foreign INTY) IARYLAND
			Usual Residence of Decedent				Jan. 1	0, 1713		EMCLERAD
	rylan show	_	10a. State 10b. County 10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Ba-f :	Director	MARYLAND WASHINGTON			SBORO				1 ☐ Yes 2 🖾 No
	vith th		10e. Street and Number		10f. Zip Code	04.74		10g. Citizen of		,
	is 23	eral	21131 GREENBRIER ROAD 11 Marital Status 12. Was Decedent Ever in U.S.	12	Was Docadart of Hi	2171			U.S.A	A.
"	fter d r Iteπ iner	Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 🖫 No	13.	If Yes, specify Cuba	n, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	Bla	ack, White,	
036	urs a	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1∐Yes 2⊠No	Specify:		Speci	fy: W	HITE
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, I'm Madical Eraminer must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupa		of working	16b. Kind of E	3usiness/Ir	ndustry
121	within jene. than "	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired,)	9	IIDI ITA	C 17T7	NEWS A TOTAL TO A TOTAL
2	filed v Hygie other t	ပိ	10 17. Father's Name (First, Middle, Last)		FARMER		's Name (First, Middle			SETABLE FARM
an	thould be filed and Mental Hygin marked other matic event, I	To Be	WALTER CLARENCE SCHILDT				SNYDER	,	/	
Maryland	2 should be f and Mental I is marked of aumatic eve	ř		9b. Maili	ng Address (Street a		r or Rural Route Numi	ber, City or Town	n, State, Z	ip Code)
	ad 2 Iff		MARK A. BOWMAN/GRANDSON 2	1265	MT. LENA	ROAD	, BOONSBOR	RO, MARY	LAND	21713
ore	ges 1 ar it of Hea if item or other		20a. Method of Disposition 20b. Place 20c	of Dispo	osition (Name of matory or other place	e) -	Date 7/10/0, 7/2	20c. Location 2/08	- City or T	own, State
Ë	Pag tment tant: I				O CEMETER		/22/2008	BOONSBO		MARYLAND
Baltimore,	permit. Pages : Department of I Important: If ite any Injury or of		21. Signature of Europa Service Licensee				BAST-STAUF			
			Refly A. Zimmerma 23a. April 1. End the disease or complications that caused the death. D						<u>o, MD</u>	21713 Approximate
00	Dhusisian		shock, or heart failure. List only one cause on each line.		•			anosi,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a		us cular		cranu		\rightarrow	16 Kous-
	Examiner			·						
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated earns.	e of):						
_	xecut and Il-tran	хап	that initiated events resulting in death) Last C	e of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical E		/ -						
89	tificating phy as the	edic	u.							
Вох	eath certific attending p for use as	N/us	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal decedent	ath al	☐ Ectopic pregnancy	,		23d. D	ate of deli	very
O. B	e dea	Physician/Me	1 Yes 2 No 4 Pregnant at time of death		Other (specify)	у		, n	/lonth	Day Year
<u>P.</u>	that the de ned by the a detached		9 Unknown Part II. Other significant conditions contributing to death but not resulting	n in the u	nderlying cause give	en in Part	23e Did	tohacco use co	ntribute to	the cause of death?
ds,	w requires t been signe should be o	d by	() Carni atria	7 -	ilida	Qui.		Yes 2 No		
Vital Records	w requ	Completed	(D) Herneller Sin.				24a. Wa	s an 24h	Were au	topsy findings available
Re	The lay	dwo	(3) dilate (700 8)	. 1	***		auto per	opsy formed?	prior to c death?	completion of cause of
	ician: The certificate ector, pag	ø	25. Was case referred to medical	4 1	neo jais	26. Place	1 ☐ Yes of Death (Check only		1 ∐ Yes	2 No
	Physician: this certific al director,	To B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/	Outpatie	nt 3 DOA Othe	or.	rsing Home 5 🗆 Res		ther (Sper	cify)
	nding Physician: th. : After this certific: ? funeral director, p	on:	27. Manner of Death 28a. Date of Injury 28l 1 ☐ Natural 5 ☐ Pending (Month, Day, Year)	o. Time o	f 28c. Injun Work	y at (?	28d. Describe	how injury occu	urred	
Sio	the the	cati	2 ☐ Accident investigation			Yes 2□N				
\leq	Dir o	Certification:	4 Homicide 4 Homicide 4 See. Place of Injury - At home, building, etc. (Specify)	tarm, st	reet, factory, office			(Street and Nur own, State)	nber or Hu	iral Route Number,
	Hospital 24 hours a Funeral I etely filled	alC	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowled	dge, deat	h occurred at the tir	ne, date an	d place, and due to th	e cause(s) and	manner as	s stated.
	he Ho in 24 I he Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or in	nvestigation, in my o	pinion, deat	th occurred at the time	e, date and place	e, and due	to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier Proposition	des	29c. License	e number		29d. Date sign		
			Francisco ANONDOE M.I.	2.	Do	1898		111	18/08	
2	H-8		30. Name and address of person who completed cause of death (Item 23		. '	4000	form, fr	in 2/7	(N)	
	Sta	te	31. Date filed (Month, Day, Year) 32. egistrar's Signature	,,,	iel St. H	July	-10001 M	0 - 01)		
	Registr	ar	JUL 2 1 2008	1	2016					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23a State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per me 9882 dbb Reg. No. 2008 24533 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** ttrlene Evans 2236 12 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maryland Bathwa If Under 1 Year If Medical Cento UNIVERSIM 0 8. Date of Birth (Month, Day, OCT 14, If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year 1921 1 □ M 2 🛣 F Months Days Hours NEW YORK 86 **Director** 215-44-5893 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show s 23a or 28a-f shor 1 XYes 2 No Director DENTON CAROLINE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21629 420 COLONIAL DRIVE USA Funera items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status the Medical Examiner. 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3X Widowed 4 □ Divorced within 72 hours Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) marked other than Elementary/Secondary (0-12) MEDICAL 12 REGISTERED NURSE permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MILDRED LANGDON CARLETON HUGH EVANS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1900 CREEKSIDE DRIVE, WHEATON, ILLINOIS 60187 RICHARD C. BAYBUTT/SON Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition W Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN MEMORIAL PARK 7/18/2008 4 ☐ Donation 5 ☐ Other (Specify) EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 200 S. HARRISON ST., EASTON, MD 21601 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Subdura disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rebrivasci Discase Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed EXAMINER ardiovasanlar CERTIFICATION APPROVED BY MEDI the burial-tran and Due to (or as a consequence of) Box 68760. physician Physician/Medical as attending use a IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? ò Month Day Year 5 Other (specify) 0 the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? The law 24a. Was an has page 2 autopsy ate 1 ☐ Yes 2 ☐ No of Vital 1 □Yes 2 2 No s certific. Physician director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes Yes 2 <u></u> ⊢N0 ဥ 1 hpatient 2 ER/Outpatient 3 DOA after death.

Director: After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Attending Division 5 Pending investigation 2X Accident 3:22 a 1 ☐ Yes 2 🙀 No Subject fell out of bed. 06/12/2008 completely filled in by the 6 □Could not be Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State 420 Colonial Drive 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ō To the Hospital within 24 hours a To the Funeral D Nursing Home Denton, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29al Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number atur

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State

Registrar

DHMH 17 Rev 1/2001

Greene

13,2008

Bathmore, MD 21201

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ye1' 6 2008

Williams

			For State Registrar		State of N	Maryland	d / Depa <i>Cei</i>	artment of F rtificate of	lealth <i>Death</i>	and Me 1	ental Hyg R	iene eg. No	2008	24534
	Physicia	an	1. Decedent's Name (First, Middle, Last) BETTY ANN BOERUM 2. Date of Death July 11, 20							Year	3. Time of Death 7:20 A M			
		/Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location							,,	_	County of Death			
	Funeral Director	1 1 217 26 07E1 1 11 M 2ME 1 60					ast birthday) Yrs.	West River If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. March			8. Date of Birth (Month, Day March 30			
Baltimore, Maryland 21215-0036	aryland show d at	_		ecedent Ob. County Anne Arund	1 □ Ves 2 2 2 1						0d. Inside City Limits 1 ☐ Yes 2 No			
	h with the Mi 23a or 28a-f st be notifie	Funeral Director	Maryland Anne Arundel West River 10e. Street and Number 10f. Zip Code 10g					10g. Citi	zen of What Cour					
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	ρ	11. Marital Status 1 □ Never Married 2 N Married 3 □ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 □ N If Yes, Give A Year or Dates:			s? No	If Yes, specify Cuban, Mexican, Puerto				ify Yes or No- lican, etc.)	y Yes or No- zan, etc.) 14. Race - American Indian, Black, White, etc. Specify: White		
	ithin 72 hou ne. nan "natura e Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5			or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Bus Driver					16b. Kind of Business/Industry Transportation		
	d be filed w ental Hygier ced other ti c event, th	To Be Co	12 17. Father's Name (<i>First, Middle, Last</i>) Unknown				18. Mother's Name (First, Middle, Maiden Surname Alice Harris							
	and 2 should alth and Me 27 is mark er traumati		19a. Informant's Name/Relationship (Type. Print) Warren Boerum/Husband 19b. Mailing Address (Street and Number or Rural Route Number, Co. 819 Elm Drive, West River, Md. 20778)						8					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispose 1 Burial 2 Dispose 4 Donation 5	Cremation 3 ☐ ☐ Other (Specif)		iie	as Cren	osition (Name of matory or other planatory natory 2. Name and Addre	ess of Fac	7–15–0	ge P. Ka	Edge las l		ryland me
P.O. Box 68760,	cate be executed Medical Examiner the burial-transit	al Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First of the transfer of the properties											
	death certifi e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 1 profiths? 1 Yes 2 No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery Month Day Year				
	law requires that the de as been signed by the a 2 should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tob						1	acco use contribute to the cause of death? s 2 No 3 □ Probably 4 □ Unknown				
al Records,	The la ate has page 2	Completed									24a. Was autop perfo 1□ Yes		prior to co	opsy findings available ompletion of cause of 2 ☐ No
r Vital	Physician: The this certificate ral director, pag	To Be	25. Was case referre examiner?	1	Hospital: 1 ☐ Inp	atient 2	ER/Outpatie	nt 3□ DOA Ot	her	ace of Death Nursing Hon	(Check only o		6 □Other (Speci	ify)
Division or	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Certification:							Street ar	and Number or Rural Route Number,				
_		Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [Check only one)											
	To th within To th comp	S Me	29b. Signature and ti		ming	>		29c, Licen	se numbe				ate signed (Month	
,	X CO		30. Name and address	wer	ner, MC	of death (Item	3 (Type	Print) Get Roca	世	300	Annap.	>115	MO	2140/
	Sta Regist		31. Date filed (Month	, Day, Year) L 15 200		gistrar's Signa	ature	adi						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day **Physician** 1923 P M Isabelle Alice 2008 Beckham Ju₁y 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01nev Montgomery Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min 1 □ M 2 🕅 F 578-30-0714 Director 100 11/17/1907 SC Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extending the input to a conflict 28a-f show 1 Yes 2 No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 2924 Bel Pre Road #302 20906 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 21 No Specify ð 3K Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th Caregiver Selfemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pink Broom ပ Anne Barber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah Fewell/Niece 2924 Bel Pre Rd #302 Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Memorial Cem. 7/18/2008 Suitland, Maryland 22. Name and Address of Facility Marshall's Funeral Home 4217 9th Street, NW Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. In not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of hstruction Examiner Sequentially list conditions, Examine n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (of as a consequence of) eath certificate be executed trar that initiated events resulting in death) Last Due to (or as a consequence of): burial atten fing physician for use as the burial Box 68760. Physician/Medical the use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) signed by the a ☐Yes 2 No o 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 2 **2** No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manny of Death 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? After 1 To the Hospital or Attending within 24 hours after death. 1 Natural 5 Pending after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature 2 Tile of certifier 30. Nam vind address of prison with completed cause of death (Item 23a) (Type, Print) Maryland 20832 V. Williams Olney, 18101 Prince Phillip Drive 31. Date filed (Month, Day, Year) egistrar's Signature State 16 JUL 2008 Registrar

			1- For State of Maryla		artment of He		ental Hygier	2002	24536		
	Physicia		1. Decedent's Name (First, Middle, Last) Ronald Warren Brown				2. Date of Death Month 07 10	Day Year	3. Time of Death		
,	/Medic Examin		4a. Facility Name (If not institution, give street and number) St. Thomas More Nursing Home		4b. City, Town, or L			4c. County of Death Prince Geo	rgae		
San	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yr.	rs. last birthday) 52		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yel 01/21/195	9. Birthp	lace (State or Foreign try) ngton, D.C.		
Datimore, Mary yield 21213-0030	e Maryland a-f show tified at	ctor	10a. State 10b. County 10c. 0	City, Town or Lo				11	0d. Inside City Limits XXYes 2 □ No		
	ath with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 3652 Park Place N.W.		10f. Zip Code 200			Citizen of What Coun			
	ours after decreal; or items	ð	11. Marital Status 1	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - America Black, White, of Specify: Bla			
	within 72 ho ene. than "natur ne Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Oth College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fratropropour				16b. Kind of Business/Industry			
	uld be filed Aental Hygi rked other tic event, ti	To Be Co	9th Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maio Robert G. Brown Erlease Arner						Self Employed den Surname)		
	and 2 short ealth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Robin Brown/Sister	3652	Park Place	N.W., W	ashington	ty or Town, State, Zip	, and the second second		
	nt. Fages I intment of He intant: If Iten injury or oth		Tourial 2 Defination 3 Themoval from State	tropoli	sition (Name of matory or other place, tan Cremat	ory 7/15	/08 A1	Location - City or To exandria, 'uneral Hor	V.A.		
0	permi Depar Impor any ir		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	4:	217 Ninth	St. N.W.	Washingt	on, D.C.			
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consci	nnunc equence of):	deficie	ncy Vir	us (A	105)	Onset and Death		
DIVISION OF VICE INCIDENT The law requires that the double desired has the double desired by second the	icate be executed physician and sthe burial-transit	Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of). c. Due to (or as a consequence of): d.								
	the death certifically the aftending phiched for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23c. If yes, outcome pf pregnancy 1 Clive birth 2 Fetal death 5 Other (specify)						23d. Date of delivery Month Day Year		
	w requires that the de been signed by the s should be detached		2 / 2 / 2 / 2 / 2 / 2 / 2 / 2						o use contribute to the cause of death?		
	sician: The law re certificate has be irector, page 2 sho		Anemia Hejdatitis C Belatchal Lower Extremity Vicers due to drug use 1 yes 20 No 1 yes								
	Physician r this certifieral director		25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
IN SIGN	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		27. Manner of Death 28a. Date of Injury 2								
	the Hospi nin 24 hour the Funer npletely fill	Medical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
,	noo Pinin	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)								
	-04		30, Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL A DEVERT MD 4703 QUEARSORY Rel Hyatkuille MD 2018/ 31. Date filed (Month, Day, Year) 32, Registrar's Signature								
	Sta		IIII 1 C 2000	4	- as						

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_	4	J	J	

			For State Registrar	State of Maryland / I		artment of Healtl tificate of Dea			giené UUÖ leg. No.	24551
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
	Physici		Ira	Benson				$\operatorname{July}^{ ext{Month}}$	5 2008	6:20 A M
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)	_	4b. City, Town, or Locati	ion of Death		4c. County of Death	
			Crescent Cities C	enter		Riverdale			Prince Geo	rge
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit		If Under 1 Year If Un Months Days Hou	der 24 Hrs.	8. Date of Birth (Month, Day	9. Birth	place (State or Foreign ntry)
	Director		224-10-2420	IM 2□F 96	Yrs.	Indiana Bayo 1100				arolina
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or Lo	cation				10d. Inside City Limits
	aryla	5								1 ∑Yes 2 ☐ No
	1881-1	Director	MD Prince Ge	orges River	da1				10g. Citizen of What Cou	
	with the property of the prope	늅		1		10f. Zip Code		'		nu y :
	s 23	erai	4409 East West Hi	gnway 12. Was Decedent Ever in U.S.	12.1	20737 Was Decedent of Hispanic	Origin? (Spe	oify Ves or No-	U.S.A.	can Indian
	e filed within 72 hours after death with the Maryland I Hygiene. other than "natural", or Items 23a or 28a-1 show ent, I're Madical Examiner must be notified at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	13.	f Yes, specify Cuban, Mex	cican, Puerto	Rican, etc.)	Black, White,	
36	irs af		3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		I∐Yes 2∭ No <i>Spe</i> o	cify:		Specify: Bla	ck
21215-0036	2 hou	Completed by	15. Decedent's Educ		. Dece	dent's Usual Occupation			16b. Kind of Business/In	dustry
215	in 7.	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. i	kind of work done during r DO NOT use retired)	most of workii	ng		
21	d with	Eo	12		roc	ery Store CL	erk]	Private Indu	ıstry
덛	be filed within 72 ho stal Hygiene. od other than "natur event, II e Medical	Bec	17. Father's Name (First, Middle, Last)			18. M	lother's Name	(First, Middle,	Maiden Sumame)	
<u>a</u>	should be ind Mental i marked o umatic eve	To E	Willie Benson			M	laggie	Barnes		
Maryland	s man	ľ	19a. Informant's Name/Relationship (Type			ig Address (Street and Nu				Code)
	of Health of Health of Health of Health of them 27 is other tree		Willie Ira Benson,			Burnside Rd.				
ore	of Heritan		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	amoval from State 20b. Place o	of Dispo ory, crer	sition (Name of natory or other place)		ate	20c. Location - City or To	
Ĕ	Pag nent ant: I		'4 □Donation 5 □ Other (Specify)	Fort	Lin	coln	July	11,2008	Suitland,	Md.
Baltimore,	permit. Pages Department of the important: If ite any injury or of once.		21. Signature of Funeral Service License		22	. Name and Address of Fa	acility Lat	ney's F	uneral Home	,Inc.
<u>m</u>	20 E 20		1	278	3	831 Georgia	Ave. N	.W. Wa	shington,D.	C. 20011
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. Do	not ent	er the mode of dying, such	n as cardiac o	r respiratory arr	rest,	Approximate Interval Between
2	Pnysician	i in	Immediate Cause (Final disease or condition	Fatal cardiac	ar	rhymia				Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence	of):					
н	Examiner		Sequentially list conditions,	Prostrate Can	cer					
	p .=	ner	if any, leading to immediate	Due to (or as a consequence	of):					
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
, 0	e exe	ŭ	resulting in death) cast	Due to (or as a consequence	of):					
68760,	icate be executed physician and s the burial-transit	dicai								
	entific ding p	Me	IF FEMALE:	20 Maria automa of manage						
Вох	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death		Ectopic pregnancy			23d. Date of deliv Month	ery Day Year
0.	D 00 D	sic	1 Yes 2 No	4□Pregnant at time of death 9□Unknown	5 L	Other (specify)				
<u>a</u> .	The law requires that the ste has been signed by th page 2 should be detache		Part II. Other significant conditions con	tributing to death but not resulting i	in the u	nderlying cause given in P	Part I	23e. Did to	bacco use contribute to t	he cause of death?
JS,	ires t signe	þ	Coronary artery			identifying dadde given in the			es 2√2 No 3 ☐ Prol	
5	w require been si should t	Completed						-		
Sec.	e law has t	npi	Renal insufficier	ıcy				24a. Was a autops perfor	sy prior to co	opsy findings available empletion of cause of
=		S							2☑No 1☐Yes	2□ No
Vital Records,	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:				(Check only or		
ō	Phys this al dii	2	1 ☐ Yes 2 🖾 No	I inpatient Za_RervOi	utpatier Time of				ence 6 Other (Special own injury occurred	(y)
	e fe	ig ig	1 Natural 5 □ Pending		Injury	28c. Injury at Work? M 1 ☐ Yes 2		200. 0030100 11	ow injury occurred	
isi	an eat or: he	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, fa	arm etr			28f Location /S	treet and Number or Run	al Route Number.
É	in it is	Certification:	4 Homicide determined	building, etc. (Specify)	airii, 3ti	eet, factory, office		City or Tow		
	id of i		29a. Certifier 1K Certifying Phys	sicien: To the best of my knowledg	e. deati	occurred at the time, date	e and place	and due to the c	ause(s) and manner as	stated.
		edical		ner: On the basis of examination ar and manner stated.						
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. License numb	ber	2	29d. Date signed (Month,	Day, Year)
	->=0		QUM Yann	ellmo		D0020654			T 1 0 000	0
	5		30. Name and address of person who co		(Type	D0029654			July 9, 2008	0
			Jerry McConnell	1221 Mercantile			lary1ar	nd 2077	4	
	Sta	ite	31. Date filed (Month, Day, Year)	32. egistrar's Signature	-	Conf.				
	Registr	ar	ffff 1 0 700	18 6 6 6	De	SA62.				

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Theodosia Edith Bowler July 14,2008 12:25A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth
(Month, Day, Year)
Sept 1, 1916 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 231 – 58 – 9378 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🔀 F 91 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examinational benedified at Va 1 ☐ Yes 3 ☐ No Orange Gordonsville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Post Office #2 22942 U.S.A. Funeral death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify Black 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates 2 3₽Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Domestic f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert A Hall Piccola Dade or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Martha A Johnson (Daughter) 418 Boyd Ave Takoma Pk Md 20912 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodberry Cemetery 7/19/2008 Gordonsville Va 20a. Method of Disposition Department of Important: If it any injury or o once. 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify 22. Name and Address of Facility Mason Funeral Service 21. Signature Funeral Service 5801 Cleveland Ave Riverdale Md 20735 23a. Part 1. Enter the dis-shock, of heart failu Immediate ause inal disease or condina resulting in death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** CNGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner RENAI PAILURE Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed PHELLMONIB and the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Tyes 2 X No. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Acute Myocardio-Infarction 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was a. autopsy performed? 24a. Was an page 2 s certificate 1 ☐ Yes 2 MNo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death.

Director: Af
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D60826 July 14,2008 30. Name and address of person who completed cause of death (Item 283) (Type, Print) Dr Ksharma Garq 1500 Forest Glen Rd SilverSpring Md 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 5 2008 Registrar

			For State Registrar	State of	of Marylan		artmen rtificat			and Mo	ental Hy	giene Reg. No.	711118	24	539
	Physici /Medic		1. Decedent's Name (First, Midd James Benne		e						2. Date of De Month July	eath Day	2008 Year	3. Time of 6:40	P M
	Examir		4a. Facility Name (If not institution Forestville Head Center	alth & Reb	nabilita	tion	For	estv	Location o			4c. Pr	County of Death	rge's	
	Funeral Director		5. Social Security Number 578–09–0954	6. Sex 1 ½ M 2□ F	7. Age (In yrs.	95 Yrs.	Months Months	1 Year Days	If Under : Hours		8. Date of Bir 2//31/1	912"	9. Birth	lary s	r Foreign Co 🛶 MI
	e Maryland a-f show lifled at	ctor	Usual Residence of Decedent 10a. State 10b. County MD Char	rles		y, Town or L Brandyv						•	1	10d. Inside Cit	
	with the	Director	10e. Street and Number 12509 Plantatio	on Drivo	-		10f. Zip		2			10g. Citi	izen of What Cour	ntry?	
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 ☑ Widowed 4 □ Divorced	12. Was Dec Armed F ried 1 Yes If Yes. G	2 X No ive		Was Deced If Yes, spe 1 Yes	2 \X No	spanic Orion, Mexican Specify:	gin? (Spec i, Puerto F	cify Yes or No Rican, etc.)		Specify:	ican— nericar	n
21212	d within 72 giene. r than "na the Medic	Completed	(Specify only higher Elementary/Secondary (0-12) 7th	est grade completed)	1-4or 5+)	(Give	kind of wo DO NOT u	rk done d se retired	luring most ')		g istant	Ī	ocery St	-	
/land	uld be filed Mental Hyg irked othe itic event,	To Be C	17. Father's Name (First, Middle James Blake	, Last)							(First, Middle ennett		Surname)		
, mar,	and 2 sho salth and I 27 is ma er trauma	8	19a. Informant's Name/Relation: Doris B. Pope/			1250	9 Pla	ntat	ion D				or Town, State, Zip Maryland	,	
sammore,	Pages 1 and the ment of He ant; If item		20a. Method of Disposition 1 Burial 2 □Cremation 4 □Donation 5 □ Other (State 20b. Ma	Place of Disp cemetery, cre ryland	osition (Nar ematory or d Nat "	ne of ther plac 1 • Me	em. P		ate 7/19/0		ocation - City or To urel, Mary		
Dail	permit. Departr Imports any inji		21. Signature of Funeral Services	8 /	rely .	4	2. Name ar H 925 B	d Addres .S.W. urro	s of Facilit ashin ughs	gton Ave.	& Sons	s Co. Wash:	.,Inc. ington,D	.C.200	19
	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on Adva	caused the deat each line. INCE Can (or as a conseq	cer of								Approximate Interval Bett Onset and I	ween
,007	certificate be executed rding physician and see as the burlal-transit	al Examiner	Sequentially list conditions, if any leading to him out at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	(or as a conseq	<u> </u>									
O. BOX 68/		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live	itcome pf pregna birth 2 ☐ Feta nant at time of d	aldeath 3	⊒Ectopic pi ⊒ Other <i>(sp</i>						23d. Date of delive	. ,	/ear
ecords, F.	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	by	Part II. Other significant condit Hypertension		leath but not res	ulting in the u	underlying c	ause give	en in Part I.				use contribute to t		
r	The law re cate has bee page 2 sho	Completed									24a. Was auto perfe	psy ormed?	24b. Were auto prior to co death? 1 □ Yes	ppsy findings ampletion of ca	available ause of
VICAL	siclan: s certific irector,	o Be (25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2 □	ER/Outpatie	nt 2□ DC	Othe	\F.		(Check only		6 □Other (Specia		
VISION OF	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Certification: T	27. Manner of Death 1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide deterr	28a. Date (Morigation not be prized 28e. Place		28b. Time of Injury	of 2	8c. Injury Work 1 🗀 `		No 2	8d. Describe	how injur	ry occurred		ber,
5	Hospital or 4 hours afte Funeral Di tely filled in		29a. Certifier 1 🂢 Certifyi (Check only 2 ☐ Medica	ng Physician: To th	e best of my kno	owledge, dea	th occurred	at the tin	ne, date an pinion, dea	d place, a	nd due to the	cause(s) and manner as s	stated. o the cause(s)
•	To the within 2 To the comple	Medical	29b. Signature and title of certific		ner stated.		290	D5	number				te signed (Month,		
	Syc		30. Name and address of person Bahram Pishda	who completed cau	se of death (Iten 1328 Sou	n 23a) (Type uthern	Print) Ave.	, S.I	E. #3	10, V	ashing	gton,	D.C. 20	0032	
	Sta Registr		31. Date filed (Month, Day, Year, JUL 1 7 2008		Registrar's Signa										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 2008 1:55 PM July 13, Julius Tyrone Boardley /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Gilchrist Hospice Center Baltimore Towson Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☑ M 2 ☐ F Yrs 7/20/1951 Director 56 Washington, DC 220-56-2945 Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination must be indiffed at 1√2 Yes 2 □ No Director Maryland Prince George's Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20781 United States 5805 42nd Ave. # 412 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐Yes 21 No Specify. þ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) County Government Counselor Homeless Shelter 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other any Injury or other traumatic event, III. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lola Lane Julius James Boardley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anissa Devlin / Daughter 10312 Twin Knoll Way Upper Marlboro, Maryland 20772 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/19/2008 | Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cem. 22. Name and Address of Facility Pope Funeral Home, P.A. 21. Signature of Funeral Service Licenses 70085 5538 Marlboro Pike Forestville, Maryland 20747 23a. Pan 1. Her the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death epato cellular Carcinoma Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? nas performed2 1 ☐ Yes 2 ☐ No certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records,

90

Registrar

Medical

. A. Riley 31. Date filed (Month, Day, Year) 1 7 2008

4 | Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Facto MI 21204 6701

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

July 13, 2008

Please Type or Print in Black Indelible 88k. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NA Acar Month 2:35 a July William Frederick Burger 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Washington County Hospital Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 27, 1925 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) Maryland 83 219-14-9414 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Florida Largo Largo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 33771 U.S.A. 676 Rodeo Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No
If Yes, Give 42—46
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White 1 □Yes 2 No Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Railroad Pipe Fitter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Etta Bowers Burger James O. Burger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 676 Rodeo Dr. Largo, FL 31771 Rose Mary Burger-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg Mem. Park | 7-21-2008 Frostburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Hone 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARDIO-RAPINAT-RY PAI WRA disease or condition resulting in death) Due to (or as a consequence of): (Lrowe Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events ZLectrolyte Vabili resulting in death) Last Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Examiner The law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-tran Box (Records, certificate has Division of Vital or Attending Physician; After this ours after death.

neral Director: After this filled in by the funeral d within 24 hours a

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, The Medical Examiner must be notified at once.

Physician

/Medical

DH 11+1 State

31. Date filed (Month, Day, Year)

MOHAMMED

Antietam

32. Registrar's Signature JUL 1 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A212

St. Hagerstown, MO 21740

DL6892

Registrar

Physician /Medical Examiner

Funeral

Tious	Ctata of A	landand / Da		of Lloolth			and Logi	DIC.	
1 - For State Registrar	State of N	laryland / De		of Health a of Death			20 2 one	08 2451	+2
1. Decedent's Name (First, Middle,	Last)					Date of Death Month	Day	3. Time of Dea	ath
DENNIS LEE COV 4a. Facility Name (If not institution,		·)	4b. City, T	own, or Location of	of Death	_		008 5:00 1	ΡM
Genesis Elder	Care - Th	e Pines		Easton			т	albot	
	6. Sex 7. A	ge (In yrs. last birtho	(ay) If Under		24 Hrs.	8. Date of Birth (Month, Day,) JAN 24,1	/ear)	Birthplace (State or For Country)	reign
218-34-8876	1 X M 2□ F	70 Yrs	S. Working	Days	IVIII.	JAN 24,1	938	MARYLAND	
Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City L	imits
MD TA	LBOT	1	EASTON					1 X Yes 2	□No
10e. Street and Number			10f. Zip	Code		10	g. Citizen of	What Country?	
29359 DUTCHMANS	LANE			21601				USA	
11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. Was Decede	ent of Hispanic Ori ify Cuban, Mexica	igin? (Spe	ecify Yes or No- Rican, etc.)		ce - American Indian, ck, White, etc.	
1 Never Married 2 Marrie	d 1 □ Yes 24 If Yes, Give] No	1 □ Yes 2			,		by: WHITE	
3 ☐ Widowed 4 ⚠Divorced	Year or Dates		ecedent's Usual	Occupation		14		susiness/Industry	
15. Decedent's (Specify only highest	grade completed)	(G	Give kind of world fe. DO NOT use	k done during mos e retired)	t of worki	ng '	ob. Kind of E	daliless/ilidustry	
Elementary/Secondary (0-12)	College (1-4or		OWNER				SERVI	CE STATION	
17. Father's Name (First, Middle, L	ast)	•		18. Mothe	er's Name	(First, Middle, Ma	aiden Surnai	me)	
WILLIAM THOMAS	COVEY			H	ELEN	TOWERS			
19a. Informant's Name/Relationshi								, State, Zip Code)	
DENNIS LEE COVEY	, JR./SON					EASTON,			
20a. Method of Disposition 1		9	crematory or ot	her place) METERY				- City or Town, State MARYLAND	
21. Signature of Funeral Service L	icensee			Address of Facili		I & NEWNA	M FUN	ERAL HOME PA	
JOHN K	MERCE	RON	200 S.	HARRISO	N ST.	, EASTON	, MD	21601	
23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that cause only one cause on each	ed the death. Do not line.	enter the mode	of dying, such as	cardino	or respiratory arres	st,	Approximate Interval Betwee Onset and Dea	en th
Immediate Cause (Final disease or condition	_a. Maj	SIVE C	ereb	10 Vasa	ya	~ into	ret	6 w/4	~
resulting in death)	Due to (or a	s a consequence of):							
Sequentially list conditions,	b. Don't form	s a consequence of):							
Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (5) 0	e a consequence on.							
that initiated events resulting in death) Last	c Due to (or a	s a consequence of):	:						
	d								
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e pf pregnancy 2 Fetal death	3 ☐ Ectopic pre	ananay			23d. Da	ate of delivery	
in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death	5 ☐ Other (spe				М	onth Day Yea	r
9 Unknown						00 Pilil			
Part II. Other significant condition	is contributing to death	out not resulting in tr	ie underlying ca	use given in Part i	l,	23e. Did toba		atribute to the cause of deat	
77	X V Dr. Jr. Cf	1-1	0 ~ .			1 10 10	2 1 10	3 Probably 4 Dork	IOWII
COP	I have a	V My	2/1/6	RI-V		24a. Was an autopsy	· /	Were autopsy findings ava	ilable e of
		l_				perform 1□ Yes 2	No	death? 1 ☐ Yes 2 ☐ No	
25. Was case referred to medical examiner?	Hospital:			Othor		(Check only one			
1 Yes 2 No 27. Manner of Death	28a. Date of In			4 4 NI		me 5 Resider 28d. Describe how			
1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, E		ry M	3c. Injury at Work? 1 ☐ Yes 2 ☐		200. 200020 1101	,,		
3 Suicide 6 Could no	ot be 28e. Place of in	njury - At home, farm	, street, factory,	office	1			ber or Rural Route Number	,
4 ☐ Homicide determin	building, e	etc. (Specify)				City or Town,	State)		
	Physician: To the best xaminer: On the basis and manners	of examination and/o						nanner as stated. , and due to the cause(s)	
29b. Signature and title of certifier	- A 1	(1)	29c.	License number		29	d. Date sign	d (Month, Day, Year)	
1458	ts "		6	12575	0	7	1/11/6	18	
30 Name and address of person w	rho completed cause of	death (Item 28a) (Ty	pe, Print)		^		· L.	n^^ -	
ROBERT SAN	CHEZ MA	508	IDLE	WILD	HVG	EAS	STON	1110 2160	1
31. Date filed (Month, Day, Year)	2008 32 Regis	trar's Signature	harts						

State Registrar

TLS

3

State of Maryland / Department of Health and Mental Hygien 2008 24543 Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 08 2008 04:15 PM Barbara Ann Cookson July /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 150 East Bay View Drive Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 10/16/1946 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 F Days Hours Yrs Arizona 571-68-0134 61 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ANo Funeral Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 United States 150 East Bay View Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner 1 Never Married 2 Married 1 XYes 2 No Specify: Specify: Be Completed by Spaniard Filipino 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ellis Casabar Emily Gaxiola 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health a : If item 27 is or other trai John T. Cookson/Husband 150 East Bay View Drive, Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 ☐ Burial 2 ☐ Cres Department o Important: if any injury or 07/13/2008 | Prescott, Arizona Oddfellows Cemetery 4 ☐ Donation 8 Oher (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral 2973 Solomons Island Road, Edgewater, MD 21037 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. shock, or Immediate cause (Final disease or condition resulting in death) Syeas **Physician** reast CUNCE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Natural
Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nine beeny 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestagete Read# 300 Amgolis, MOZIYO 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Maryland 21215-0036

Baltimore,

Box 68760,

P.0

Division or Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) P M **Physician** JULY 11, 2008 7:25 JAMES ANDREW CURTIS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number Year) Funeral 1**X** M 2□ F 74 11/3/1933 Washington DC 577-46-3780 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show notified at txXYes 2 ☐ No Director DC Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö must be 20020 United States 3975 Alabama Ave SE 23a Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1≿∆Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ed other than "natural", or items event, the Medical Examiner mi 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nem of Health and Mental Hygiene. ant: I item 27 is marked other than "natural", or lite ury or other traumatic event, the Medical Examiner ury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Specify: Black 1 ☐ Yes 25TNNo Specify: Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) DC Police Officer DC Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christine Curtis Unknown ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3975 Alabama Ave SE Washington DC 20020 Allyson Curtis /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or of MXBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 7-21-08 Washington DC 4 ☐ Donation 5 ☐ Other (Specify) Washington 22. Name and Address of Facility Signature of Funeral Service Pope Funeral Home 2617 Penn Ave SE 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on pach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list, conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami attending physician and for use as the burial-tra Due to (or as a consequence of): Physician/Medical the 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1□ Yes 2 No 26. Place of Death Check onl one 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 | Inpatient 2 KER/Outpatient 3 DOA After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State)

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

death

Baltimore, Maryland 21215-0036

Certification: To 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated.

500

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene gc, 7/17/08

1. & 6 per PhyCertificate of Death

Reg. No. 2 Reg. No. 2008 gc,7/ State Registrar Amended 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 16, 2008 Physician Dairsow Sr. John H. Dairsow Sr. July 3:45 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel 9812 Pheasant Run Court Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X**M 2□F 257-20-2067 Vrs 82 April 8,1926 Georgia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r 28a-f show notified at 1 ¥Yes 2 No Bridgeton Cumberland N.J. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be r USA 08302 42 Albertson Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 1946–64 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Completed by 3 ☐ Widowed 4 ☑ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electric Utility Forman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vicie Mitchell is marked Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 Albertson Avenue, Bridgeton New Jersey 08302 John H. Dairsow Jr./Son 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any injury or c 1 Burial 2 □ Cremation 3 □ Removal from State 7/21/2008 Gouldtown Mem. Park Fairfield, N.J. 4 ☐Donation Other (Specify) 22. Name and Address of Facility 21. Signature of Fineral eryce License Beall Funeral Home 6512 NW Crain Hwy Bowie MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the attending p as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9□Unknown 9 Unknown ģ signed k I be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 des 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? The certificate 2, 🖵 Division or Vital director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 6 Dother (Specify) Hospital: Other: 4 ☐ Nursing Home 55 Hesidence 1 ∏Yes 2 ☑ No 2 ER/Outpatient P 1 Inpatient 3 DOA this House 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Injury or Attending 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) othe Funeral Direct 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 2 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Van Dusen Road suite 130 Laurel, mp 7350 Laton 32. Registrar's Signature 31. Date filed (Month, Day, Year, State JUL 1 7 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2 1 8

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) FRIDLE Physician DURTNE 08 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL LINIHICM TATE CHESAPEAKE HOSPICE HOUSE If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) **Funeral** Months Days Hours VIRGINIA M 2□F Yrs. FEB.24,1919 Director 227 14 2681 Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Evancinar must be notified at 1 ☐ Yes 2 No Director MARYLAND PRINCE GEORGES NEW CARROLLTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 20784 6130 84th AVENUE Funeral 12. Was Decedent Ever in U.S. Arroed Forces? 1 [∄Yes 2 □ No If Yes, Give Year or Dates: 1942–46 14. Race - American Indian, Black, White, etc. . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WITTE Specify: ð 3√ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. POST OFFICE POSTAL CARRIER 12 should be filed with and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ERNEST LEE FRIDLEY MAE HORNBARGER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) , 1 and 2 s of Health a ARTHUR C. FRIDLEY (SON) 1584 SNUG HARBOR ROAD SHADY SIDE MD. 20764 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1 a
Department of He
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any injury or oth 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State KALAS CREMATORY 07-12-2008 EDGEWATER, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 1 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Do not enter the such as cardiac or respiratory arrest on **Physician** resulting in death) /Medical consequence of) Examiner Se uentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of) certificate be executed burial-transi Exami and Due to (or as a consequence of): physician at the burial P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Day Month 5 Other (specify) signed by the ar □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HUSPILL Hospital: 1 | Yes 2 | 1 | Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State

31. Date filed (Month, Day, Year)

JUL 1 5 2008 Registrar

29b. Signature and title of cartifie

. Registrar's Signature

Name and address of person who, completed cause of death (Item 23a) (Type, Print)

1. [HAEL] Late NTA WAY YUT DEFENSE HIGHWAY ANNAPOLD MOZIYUT

29c. License number

State Registrar POWDER

MILL RP. CALVERTON MO. 20705

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

4041

32. Registrar's Signature

VERGARA-SOARES

16

31. Date filed (Month, Day, Year)

JUL

08-05382 Frederick Ford

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 24549 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 13, 2008 1832 hrs Medical Examiner Frederick A. Ford 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Rowie** Prince George's **Bowie Health Center** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State_or 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** reign D.C. Country) Washington Months Hours Director 1 X M 2 F Yrs /26/1948 <u>578-66-3273</u> Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No notified at once Marvland Prince George's Capitol Heights with the Maryland Director 10g Citizen of What Country? 10f. Zip Code ted States 6504 Clearfield Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after death witner of Health and Mental Hyghan Mental Hyghan faite. If item 27 is marked other than "natural", or items or other transmatic event, the Medical Examiner must be White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2X No Yes Specify: Black If Yes. Give Year Yes 2 X No specify: 3 Widowed Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Field Maintenance Tech. National Park 12 3 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther B. Taylor Joseph Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) M <u>LaVerne</u> Hall 6504 Clearfield Court Capitol 1 Heights, MD 20 20c. Location - City or Town, State MD 20743 Date 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 7/21/2008 | Landover, Maryland 21. Sin ature of Funeral Service L censee Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Maryland 20747 Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Heroin intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a,27,28a-f, perME, g881 7/31/08 TT X UNPENDED attending physician or use as the burial -The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? certificate has performed? ✓ Yes 2 No Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director, 25. Was case referred to medical Be examiner? Hospital: Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 🗸 Yes 2 No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: unk Natural Yes 2 X No Pending 7/13/08 Fnd 6:36 pm 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide or Town, State)
2003 Delsol Ct. Bowie, MD determined Found in backyard Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier O.C.M.E. July 14, 2008 rassel

State Registrar

Registrar's Signature

Assistant Medical Examiner

30. Name/and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD Date filed (Month, Day Year)

OCME

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 5,2008 **Physician** 9:49p M Folgar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 6,1952 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F 55 July Guatemala 114-46-2921 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10h. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Silver Spring MD Montgomery 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11015 Childs Street 20901 Guatemala Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other there any Injury or other trainment. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □XYes 2□ No Specify: Guatemalan White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none Disabled 12 18. Mother's Name (First, Middle, Maiden Surname)
Emma Valdez 17. Father's Name (First, Middle, Last) Be Miguel Angel Folgar ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 11015 Childs Street Silver Spring, Md20901 Evelyn Arocho/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 7/17/2008 Silver Spring, Md Gate of Heaven 4 Donation 5 Other (Specify) Funeral Service Licens PATEMENT AMORES ROTTON ALDI FUNERAL SERVICE, P.A 21. Signature of 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ischemic heart disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner <u>Diabetes mellitus</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 | Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 2 XNo g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End stage renal disease 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performed? Yes 21 No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 XYes 2 No ဥ 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date-signed /Month. Dav. Year! 29b. Signature and title of certifie 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bethesda, Md 20814 4915 Auburn Avenue #104 Gail Seiken MD 32#Registrar's Signature 31. Date filed (Month, Day, Year) State 1 6 2008 Asset 1 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 8:10 P M James J. Glover 16, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 14269 Triadelphia Mill Rd. Dayton Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral X** M 2 □ F Days Hours Director 301-07-9669 89 9/24/1918 Indiana Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Md. Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3513 MacCubin Valley Trail 21042 USA r death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XYes 2 No 1942— If Yes, Give Year or Dates: 1946 filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: White Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4yrs Business Consultant Self Employed nd 2 should be filed value and Mental Hygie 27 Is marked other r traumatic event, the marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Glover Laurine Ebner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is
any injury or other trau Catherine G. Perolman/daughter 3513 MacCubin Valley Trail Ellicott City, Md. 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Ardent Crematory Inc. 4 □ Dopation 5 □ Other (Specify) 7/17/2008 Hanover, Md. 21. Signature I Funeral Bervice Licens 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a P.O. 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 Yes 2□No 1□ Yes or Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Kether (Specify) Living Hospital: 1 Yes 2 No 2 ER/Outpatient P 1 Inpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 280280 7/17/2008

State

VICTOR MADRID 31. Date filed (Month, Day, Year)

JUL 17 2008

700 607PERD 32. Resistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

CATONSVILLE NO

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10 7:20PM JULY 2008 FRANCIS U. GOLT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S CENTREVILLE CORSICA HILLS NURSING CENTER 8. Date of Birth (Month, Day, Year) JULY 4,1917 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1**X** M 2□ F MARYLAND 91 Yrs. 220-12-4827 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any highry or other traumatic event. The Medical Examiling in 1981 be indiffied at once. Yes 2 No Director QUEEN ANNE'S CENTREVILLE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21617 205 ARMSTRONG AVE. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 Yes 2 No Baltimore, Maryland 21215-0036 þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) AGRICULTURE 6 FARMER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARY FAVINGER URBAN THOMAS GOLT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) NANCY HOLLENY/DAUGHTER 8286 LAUREL LANE, DENTON, MD 21629 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State CHESTERFIELD CEMETER 7/15/2008 CENTREVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or an a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No been signed by the s should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 ☐ Yes 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: XXNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 this Director: After th 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 ∰Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours aft te Funeral Di tetely filled in 1 🔁 Contifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 WILLIAM H. ROBINS 200 CIVIC AVE., SALISBURY, MARYLAND 21804 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 15 **Physician** 2008 JULY 2:55PM M CHARLES B. HAAS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT EASTON WILLIAM HILL MANOR If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** OHIO Months Days JULY 8, 1917 1 XM 2 ☐ F 91 Director 272-05-0996 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.
em 27 is marked other than "natural" or home on 27. 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director TALBOT ST. MICHAELS MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number P 0 ral", or items 23a Examiner must b 8599 BOZMAN/NEAVITT RD. 21663 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: δ WHITE Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. GOVERNMENT MECHANICAL ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES H. HAAS MABEL S. MCKISSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8599 BOZMAN/NEAVITT RD., ST. MICHAELS, MD 21663 ANNE K. HAAS/WIFE permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State CHESAPEAKE CREMATION CTR 7/16/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 JOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia **Physician** 3 weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★☐ Unknown Completed Insufficience 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2FINO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 454 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident neral Director; , filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7 15/02 1242816 15710 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) is wisonne 555 Cupalitad Dr. - 13500V 31. Date filed (Month, Day, Year) JUL 1 6 2008

Registra

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 13 Day **Physician** 200g 6:09 Рм Henry L. Hamilton, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Aug. 17, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) 1911 Hours 1 M 2 □ F 218-36-2754 96 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20716 17200 Central Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: <u>^</u> 3 Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Agriculture Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hi ant: If item 27 is marked oth Be Annie Sturgis Henry L. Hamilton, Sr. ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17004 Central Ave. Bowie, MD 20716 Robert L. Hamilton, Sr. / Son permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 7/18/2008 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Beall Funeral Home 20715 6512 NW Crain Hwy. Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (I'r as a consequence of): /Medical Examiner neumonid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transi and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical as the l IF FEMALE nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No certificate has autopsy performed Mucacytoris 2 No Attending Physician; 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Tes 2 🔼 No 1 Na Inpatient 2 No ER/Outpatient 3 No DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours at er deart To the Funeral Director: completely filled i by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08 pleted cause of death (Item 23a) (Type, Print) 7503 Surratt Clinton State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Ma	ryland		artment of H		and Mental Hy	/giene Reg. No	711118	24555
i	Physici /Medio		1. Decedent's Name (First, Middle, L	Riley	H	ept	er		2. Date of D	eath Da	14 Joo	3. Time of Death 5: 25 PM
	Examin		4a. Facility Name (If not institution, g The Johns Hopkins 5. Social Security Number 6.	Hospital	/In vrs la	ast birthday)	4b. City, Town, or Baltimore If Under 1 Year	City			. County of Deat	
	Funeral Director		Unavailable Usual Residence of Decedent	1 X M 2 □ F		Yrs.	Months Days	Hours	Min. (Month, D July 8	ay, Year)		hplace (State or Foreign intry) ryland
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	ector	10a. State 10b. County Maryland Anne A1 10e. Street and Number	undel		n Burr	nie			10a Cit	tizen of What Co	10d. Inside City Limits 1 → Yes 2 □ No
	s 23a or	Funeral Director	411 North Green			120	10f. Zip-Code 21060		i-0 (0if-)	U	SA	
920	ırs after de ıl", or Item xaminer m	þ	11. Marital Status 1 ★ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 If Yes, Give Year or Dates:			vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☐ No	Specify:	gin? (Specify Yes or No , Puerto Rican, etc.))-	14. Race - Amer Black, White Specify:	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		+)	(Give :	lent's Usual Occup kind of work done DO NOT use retired r Worked	during mos	t of working	16b. K	Gind of Business/	Industry
and 2	should be filed within 7 and Mental Hygiene. s marked other than "n umatic event, the Medi	To Be Co	17. Father's Name (First, Middle, Las	it)					er's Name (First, Middl nnifer McM			-
Maryland	id 2 shoul Ith and Me 27 is marl traumatil	Ε.	19a. Informant's Name/Relationship Jennifer McMilla					and Numbe	er or Rural Route Nurni Glen Burni	ber, City	or Town, State, Z	
altimore,	Pages 1 ar nent of Hea int: If Item 3 iry or other		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control Contro		20b. Pl	lace of Dispo emetery, cren	sition (Name of natory or other place	ce)	Date 7/18/2008	20c. L	ocation - City or	Town, State Maryland
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Se vice Lice	mill	_				y Fort Lind g Rd., Bre			Home 20722
	Physician		23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition	mplications that caused y one cause on each line	the death.	Do not ente	er the mode of dyin	ng, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	CONCOUNT CONCOUNT		rosis					
,	ate be executed hysician and the burial-transit	Exan	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a	a consequ	ence of):						
68760,	rtificate be ng physicia s as the bu	Medica	IF FEMALE:	d								
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burlal-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of the control	2 🗌 Fetal	death 3	Ectopic pregnanc Other (specify)	y			23d. Date of del Month	ivery Day Year
	v requires that the death been signed by the atter should be detached for	þ	Part II. Other significant conditions	contributing to death bu	ut not resu	ulting in the u	nderlying cause g	iven in Part				the cause of death?
Division of Vital Records,	The law requate has been page 2 shou	Completed							24a. Was auto perf 1 🗆 Yes		prior to death?	topsy findings available completion of cause of 2 \square No
f Vita	/siclan: The certificate director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 MNo	Hospital:	nt 2 🗆 E	ER/Outpatien	t 3 DOA Oth	or:	of Death (Check only rsing Home 5 ☐ Res		6 ☐ Other (Spec	sify)
sion of	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending investigat			28b. Time of Injury	Wor	yat k? Yes 2 ⊡ l	28d. Describe	how inju	iry occurred	
Dİ	Ital or Attendurs after deat ral Director:	Certification:	3 Suicide 6 Could not determine	building, etc.	. (Specify)				City or To	wn, State)	ural Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	Medical		Physician: To the best of aminer: On the basis of and manner sta	examinati							
4	To the within 7 To the comple	Σ	29b. Signature and title of certifier	hatt no			29c. Licenson		4	29d. Da	te signed (Monti	1, Day, Year)
	2		30. Name and address of person where the same and address of the same address of	no completed cause of de	eath (Item	23a) (Type,				olfe S	St, Baltimo	ore, MD, 21287
	Sta Registr		31. Date filed (Month, Day, Year)	2008 32. Ruistrar	's Signatu	B A	mele					

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Maryland / Depa Ce	artment of Health and N rtificate of Death		enge UUS g. No.	24556
Discusioni e		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
Physici /Medi			nes, Sr.		July	14, 2008 4c. County of Death	9:25 A ^M
Examir	ner	4a. Facility Name (If not institution, give stre Calvert Memorial Ho		4b. City, Town, or Location of Death Prince Frederick		Calvert	
Funeral Director		5. Social Security Number 6. Sex 159-24-1837 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 11-11-19	9. Birthp Cour Reyno	olace (State or Foreign oldsville,PA
to to		Usual Residence of Decedent	100 City Town and				0d. Inside City Limits
arylar ehow	5	10a. State 10b. County MD Calvert	10c. City, Town or Lo	ocation			1 Yes 2 No
the M 28a-f	ecto	MD Calvert 10e. Street and Number	Dunkirk	10f. Zip Code	10	g. Citizen of What Cour	21
3a or	0	10707 Ward Rd.		20754	U	nited State	es
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23s or 28s-f show any Injury or other traumatic event, its Medical Examinat must be resulted at any Injury or other traumatic event, its Medical Examinat must be resulted at any Injury or other traumatic event.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1949— If 4es, Give 1952 Year or Dates:	Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 № No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: White	etc.
in 72 hour "natural"	Completed b	15. Decedent's Educa (Specify only highest grade of	tion 16a. Dece (Give life.	ident's Usual Occupation is kind of work done during most of work DO NOT use retired)		6b. Kind of Business/In	dustry
d with giene.	mo	Elementary/Secondary (0-12) 9 th	College (1-4or 5+) D.C.]	Police Officer		Law Enforce	ement
lid be file lental Hyg ked oth	To Be C	17. Father's Name (First, Middle, Last) Llyod E. Himes		18. Mother's Nam Edna Carl	ne (First, Middle, M perry	faiden Surname)	
d 2 shouth and N		19a Informant's Name/Relationship (Type Michel Brady (dau		ing Address <i>(Street and Number or Ru</i> D Lancaster Dr. St			Code)
ages 1 and on tof Health it if item 27		20a. Method of Disposition 14 Burial 2 Cremation 3 Rer	20b. Place of Disponentery, cre	osition (Name of or other place) coln Cemetery 7/18	Date 2	rentwood, N	
permit. Proportion of the post		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Scicensee	2	2. Name and Address of Facility For	t Lincol		
		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	cause on each line.				Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	OBSTRUCTIUS	E LUNC	o DISEASE	
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):				
cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
of ou,	dicai	d.					
The Cords, 7.0. DOX of The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		□ Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	very Day Year
ires that the signed by	þ	Part II. Other significant conditions contri	ributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
I necords, The law requires I cate has been sign, page 2 should be	Completed				24a. Was al autops perform	ped? prior to c	opsy findings available ompletion of cause of
VICION: The sicion: The contilicate rector, pag	a	25. Was case referred to medical		26. Place of De	1 ☐ Yes 2 ath (Check only on		2010
r VILA rysicien: nis certific	To B	examiner?	espital: 1 Inpatient 2 ER/Outpatie		1	ence 6 Other (Spec	ıfy)
ION OI nding Phy ath. r; After this e funeral d		27. Nanner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe ho	ow injury occurred	
DIVISION OF VICE To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director; After this certifica completely filled in by the funeral director, 1	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (St City or Town	treet and Number or Ru n, State)	ral Route Number,
e Hospit 124 hours e Funere letely fille	edical (29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examination	cian: To the best of my knowledge, dea er: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the curred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number	_	9d. Date signed (Month	, Day, Year)
Na		Peter 1	1	D40370		1/16/08	
12		30. Name and address of person who con Peter Wisniewski,	npleted cause of death (Item 23a) (Type MD 110 Hosptia	n. Print) 1 Dr. Suite 310 Pr	cince Fre	derick, MD	20678
	ate	31. Date filed (Month, Day, Year)	32. Restrar's Signature	1 1.			

Registrar DHMH 17 Rev 1/2001 08-05396 Shawn Klein

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		- For State	Ce	ertificate	of Death				eg. No.	۵. ۷	00	4400
Physicia		Registrar 1. Decedent's Name (First, Middle,I	.ast)					Date of Deat Month		ear	3. Time o	
e∕ొ∃l Exami		Shawn Kle	ein				J	uly 14, 20	008	- 15		TIIS
•		4a. Facility Name (if not institution,	give street and number)		4b. City, Town, o		f Death		4c. Coun	*	th	
		Harford Memorial Hospi	tal		Havre de C							
Funeral		Social Security Number 6.	. Sex 7. Age (In yrs	last birthday			r 24Hrs. 8. Min.	. Date of Bir	th(MM/DD/YY	Fore	irthplace (Sign	
Director		052-62-3903	X M 2□F 35		Yrs. Months Da	ys Hours	IVIIII.	June 2	2,1973		Country)Ne	w York
	1	Usual Residence of Decedent									Tio Live	de Cita disente
any	Ī	10a. State 10b. County	10c. Ci	y, Town or L	ocation							de City Limits
<u>*</u>	_	MD Harfor	rd Abe	rdeen	Proving G	round					-	es 2 No
Maryland 28a-f show	왕	10e. Street and Number			10f. Zip Code			1	0g. Citizen of	What Co	ountry?	
th the Maryland 23a or 28a-f sho	Director	3834 E. Liberty	Ct.		21005				USA			
s 23a		11. Mantal Status	12. Was Decedent Ever in	U.S. 13	Was Decedent of H	lispanic Orig	in? (Specif	fy Yes or No	o- 14. Ra		erican India	n, Black,
ath v litem	Funeral	1 Never Married 2 Married	ried Armed Forces? 1 X Yes 2 No		If Yes, specify Cuba	an, Mexican,	, Puerto Ric	an, etc.)	1 **	nite, etc.		l
i, or		3 Widowed 4 Divor	ced If Yes, Give Year 1992-2		Yes 2 X N	lo specify:			Speci	fy: [V	<i>h</i> ite_	
nrs af tural	ğ	15. Decedent's Education (Specif	ULDates.	16a. Dec	edent's Usual Occup	ation (Give	kind of work	done	16b. Kind of	Busines	s/Industry	
2 hou "nat	ee	Elementary/Secondary (0-12)	College (1-4 or 5+)	duri	ng most of working li		use remed	,				Į.
336 thin 72 than edical	힐	12		1	Soldier					S. A	army	
5-0036 led within 72 tygiene. other than "	Completed	17. Father's Name (First, Middle, L	ast)						Maiden Surna	ime)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Kenneth G. Kle						Giems				
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiest and Tris marked other than "matural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	ို	19a. Informant's Name/Relationshi		1.1	ailing Address (Str							- 40
ore, MD ss I and 2 sho of Health and If item 27 is her traumati		Daniela Klein/W			4 E. Libe						round or Town, St	
e, lend Heal		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from State	 b. Place of D crematory 	sposition (Name of or other place)	cemetery,		Date	200, Locati	on - City	Or TOWN, O	ate
nore Pages 1 ent of H nt: If ii		4 Donation 5 Other Spe	Δ	rlingt	on Nat. C	lem.	7/23	/2008	Arlin	gtor	.Virq	inia
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Opparment of Health and Mental Hygiene Department of Health and Mental Hygiene Important: If item 27 is marked other injury or other traumatic event, the Med	11 1	21. Signature of Funeral Service			22. Name and Addre	ess of Facilit	y Beal	ll Fur	neral H	ome		
iii iii De Per Co	01.5	AK	X	1	6512 NW C	rain I	HTATE I	20Wie	MD 207	15		2
Physician		23a. Part I. Enter the disease, or of failure. List only one cause of	om lications that caused the de	ath. Do not e	nter the mode of dyir	ng, such as o	cardiac or re	espiratory a	rrest, shock, o	r heart		ximate Interval een Onset and
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68760, certificate be nding physic se as the bun	Me	IF FEMALE:	23c. If yes, outcome of p	regnancy						te of deli		Vee
587 rrtific ling p		23b. Was decedent pregnant in the past 12 months?	t tive birti		Fetal death	3 Ectop	ic pregnand	СУ	Mon	ith	Day	Year
Records, P.O. Box 687 The law requires that the death certific cate has been signed by the attending page 2 should be detached for use as it	Physician	1 Yes 2 No 9 Unk	Pregnant at time of Unknown	death 5	Other (Specify)				1			^
he de fied fi	چ	Part II. Other significant conditi	9 Olikilowii	ot resulting i	the underlying caus	se given in F	Part I.	23e. Did	tobacco use	contribut	e to the cau	se of death?
ies that the de signed by the	À	Fait II. Other Significant conditi	one contributing to doubt out.		, ,			1 TY	es 2 V No	3	Probably 4	Unknown
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Reco The la icate h	Completed				_			1 🗸 Yes		1 🗸	Yes	2 No
tal Recian: The	0	25. Was case referred to medical	1		26.P	ace of Deat	h (Check or					
Vital hysician: this certif	8	examiner? 1 ✓ Yes 2 No	Hospital: 1 / Inpatient 2	ER/Out	atient 3 DOA	Other ₄		-	Residence	London	Other:	
of Vital Records, ling Physician: The law require. After this certificate has been s fineral director, page 2 should	=	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Tir	′ ′	Injury at Wo		28d. Describ	e how injury o	ccurred		
C := - \ =	[를	1 X Natural 5 Pend 2 Accident Inves	tigation	_		Yes 2						
Division tal or Attendi rs after death. al Director: /	<u>;</u> ë		28e. Place of Injury -	At home, farr	n, street, factory, offi	ce building,	etc.		n (Street and N n, State)	Number o	r Rural Rou	te Number, City
Division or At hours after d	Certification:	4 Homicide deter	mined (Specify)									
Hog 24 h Fur tely		29a. Certifier 1 Certifying Ph	nysician: To the best of my know	vledge, death	occurred at the time	e, date and p	olace, and o	tue to the ca	ause(s) and m	anner as	stated.	a(a)
To the Hos within 24 h To the Fun completely	Medical		miner:On the basis of examinati and manner stated.	on and/or inv				une time, da				
To with	≥	29b. Signature and title of certifie				ense numbe	er		- 1		(Month, Da	y, rear)
12		Don m	lil ino		0	.C.M.E.			July 15	, 2008	5	
		30. Name and address of person	who completed cause of death	Item 23a)								
A SE	Î	Donna M. Vincenti, M			111 Penn Stre	eet, Baltir	more, MD	21201				
	state	31. Pale filed (Month, Day, Year)	32. Registrar's Sig	nature								
Regi		JUL I 7 ZUUU	Read . K	Lagare 1	1							

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			1 - For State Registrar	State of	Maryland / D	Depar <i>Certi</i>	tment of H ificate of L	ealth a D <i>eath</i>	and M	1ental	Hygie _{Reg}		08	24558
	D		1. Decedent's Name (First, Middle,	Last)	1,130					2. Date of	of Death	Day	Year	3. Time of Death
	Physici /Medi		RICHARD L. KLE	EN						JULY		9	2008	10:15AM
	Examir		4a. Facility Name (If not institution, TALBOT HOSPI		er)	4	4b. City, Town, or	Location					nty of Death	
	Funeral Director				Age (In yrs. last birt		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of (Mont)	of Birth h. Day. Y. 25, 1	927	9. Birthp Cour NEW	place (State or Foreign TORK
	DQ		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	orloss	ution						1.	IOd Incide City Limits
	with the Maryland a or 28a-f show Le notified at	5		n o #										1 ☐ Yes X No
	28a-f	ect	MD TAL	BOT	S	T. M	10f. Zip Code				100	Citizana	of What Coul	
	with For	ā		AD.				(()			109	. Citizeri C		ntry :
	eath ne 23	era	8909 BOZMAN RO	12. Was Decede	ent Ever in U.S.	13 Wa	216		nin2 (Sn	acifu Vas r	or No-	14 R	USA Race - Americ	an Indian
5-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Heelth and Mental Hygiene 1 feet 1 feet 23a or 28a-f show Item 27 is marked other then "natural", or Iteme 23a or 28a-f show other traumatic event, Ira Medical Exaction road to notified at	by Funeral Director	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force	∍s? □ No		as Decedent of Hi res, specify Cubar Yes 2 X No	Specity:		Rican, etc	.)	В	Black, White,	etc.
5-0	72 hg	Completed	15. Decedent's (Specify only highest	Education	16a.	Deceder	nt's Usual Occupa	ation	t of work	ina	16	b. Kind of	Business/In	dustry
2121	ithin	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. DO	NOT use retired,)	. 0, 10,11	y				
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Maryland	wuld be fi Mental H arked otl	To Be	17. Father's Name (First, Middle, L					18. Mothe		RY HO			aame)	
Mar	and 2 sho elth and 127 is m er traum		19a. Informant's Name/Relationshi JOHN VALLIANT/P.			7.70	N. FORK							Code)
altimore,	of He of He I Item		20a. Method of Disposition	2	20b. Place of cemeter	Dispositi	tion (Name of tory or other place	9)	ı	Date	20	c. Location	n - City or To	own, State
Ē	Pag nent ant: I		1 ☐ Burial 2 🛣 Cremation : 1 ☐ Donation 5 ☐ Other (Spe				CREMAT		TR 7	/11/2	2008	STEV	ENSVII	LE, MD
Balt	permit. Pages 1 and 2 Depertment of Heelth a Importent: If Item 27 is any injury or other tra ange.		21. Signature of Funeral Service Li	1. Ostron	ski CFSA	FEL	Name and Addres LOWS, HI) S. HARI	ELFEN	BEIN	& NE	WNAM	I FUN	ERAL 1	IOME PA
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that cau	sed the death. Do n	ot enter	the mode of dying	g, such as	cardiac (or respirate	ory arrest	,	21001	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		heimer	10	dem	ont	ia					Interval between Onset and Death
	/Medical		resulting in death)		as a consequence of			C - 1 +						10412
	Examiner		Conventially list conditions	h										
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	cuted	Examlner	that initiated events	с										
ó,	e exe ian a urial-i	E	resulting in death) Last	Due to (or	as a consequence o	of):								
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9	e as t		IF FEMALE:											
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		ctopic pregnancy						Date of delive Month	ery Day Year
o.	the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9☐Unknow	t at time of death	5 🗆 🧿	Other (specify)				_			
P.0	that the d ed by the detached	F.	Part II. Other significant condition	s contributing to deat	h but not resulting in	the unde	arlying cause give	n in Part I		23e.	Did tobac	co use co	ontribute to the	ne cause of death?
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Ö	w requir been s should	ete								240	Was an	0.41	h Mara auto	- u findings qualible
Re	he lav e has ge 2	Completed									vegotue	d? 24L	death?	psy findings available mpletion of cause of
		e Co	25. Was case referred to medical									No	1 🗆 Yes	2⊠ No
⋚	Physician: rthis certific ral director,	00	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	Hospital:	TERIO.		3C DOA Othe			(Check o		• 🕶		HOGDTOR
of	문 판 등); To	27. Manner of Death	1 ☐ Inpa 28a. Date of I (Month,			3 DOA 28c. Injury	4 🗆 140		me 5 Ll 28d. Desc			Other (Specificurred	HOSPICE
O	th. : Afte	tlor	1 Natural 5 Pending 2 Accident investiga		Day Year) In	ijury		? ′es 2 🔲 l						
Division	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could no	ed 286. Place of	Injury - At home, fan	m, street	t, factory, office			28f. Locati	on (Stree	t and Nur	mber or Rura	I Route Number,
á	s afte	Certification;	4 Homicide determin	building,	etc. (Specify)					City o	r Town, S	State)		
	To the Hospital or Attending Phywithin 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical (29a. Certifier 1 Certifying (Check only one) 1 Certifying 2 Medical Ex	Physician: To the be xaminer: On the basis and manner	s of examination and	, death or	ccurred at the tim stigation, in my op	e, date an inion, dea	d place, th occurr	and due to ed at the t	the caus	e(s) and r and place	manner as s e, and due to	tated. the cause(s)
	To the To the Somp	Me	29b. Signature and title of certifier	A A -			29c. License	number			29d.	Date sign	ned (Month,	Day, Year)
	TLS		1 Lakshin) cuelyano	thom	MJ	DO	57	74	-7	Ju	124	10,2	008
4			30. Name and address of person w	ho completed cause of	of death (Item 23a) (Type, Pri	int)							
7			LAKSHMI VAIDYA					ST	EAST	ON. M	D 21	601		
	Sta	te	31 Date filed (Month Day Year)	32. Regi	strar's Signature	S.		,		-119 E	12 س			
	Registr	ar	JUL 15	LUU0 JOS	strar's Signature	gran	W							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year William Francis King July 12, 5:56 p 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Dec • 9 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign ^{Year)} 1938 Days Hours Months 1**⋤** M 2□ F Mary Land Dec. 220-34-4996 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Silver Spring 1 ☐ Yes 2 TX No Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20902 IISA 2106 Randolph Road #T-11 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 Automobile Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie Ada Priehe James Albert King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John David King/Son 2106 Randolph Road #T-11, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery July 18, 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burnal 2 □ Cremation 3 □ Removal from State 4 □ Condition 5 □ Other (Specify) Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial of respiratory errest, ilver Spi ingraxi 10 20 51 Interval Between Onset and Death Immediate Cause (Final CANCER LIVER disease or condition resulting in death) Due to (or as a consequence of) JUNG CANC Due to (or as a consequence of)

Physician /Medical Examiner

physician and s the burial-trans

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page 2

funeral director,

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To the Funeral Director: A completely filled in by the fu

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Physician

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altimore, Maryland 21215-0036

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "hocical Examinar mant be notified at

n and Mental Hygiene.

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Pages 1 and 2

death certificate be executed

Box 68760,

P.0.

Records,

Division of Vital Attending Physiclan: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No \$

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

Year

25. Was case referred to medical 1∐ Yes 2. No

1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 MNo autopsy performed? Yes 2 No 1 ☐Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 6 ☐ Could not be 3 Suicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only

4 Homicide

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

determined

29c. License number D64008

29d. Date signed (Month, Day, Year) 7/12/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Alsjandro Fernandez MD Holy Cross Hospital 1500 Forest Glenn Rd., S.S., MD 2090 1 6 2008 JUL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Edward Keenan July 15,2008 9:30am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9004 Wipkey Court Prince George's Bowie Months Days Hours Min. Oct. 30 , 1955 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1**X**M 2□F Director 136-52-6024 52 Texas Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 □ No Director MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9004 Wipkey Court 20720 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 2^{College (1-4or 5+)} Computer Technician Realestate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Philip Keenan Anna Ellingham ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ivone Keenan 9004 Wipkey Court, Bowie MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 21. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Colonia,NJ St.Gertrude Cem. 2008 Funera Service Licent 22. Name and Address of Facility Beall Funeral Home 21. Signature 6512 NW Crain Hwy. Bowie MD 20715 23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one plication hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Betwee Onset and Dea Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 HInknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 X No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on 1 ☐ Yes No No 27. Manner of Death Other: 4 Nursing Home Hospital: 2 ER/Outpatient 2 1 Inpatient me Residence 6 Other (Specify)
28d. Describe how injury occurred 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 🗌 No I Director: J 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours aft

To the Funeral DI

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie

Division or Vital Records, P.O. Box 68760

To the I

State

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)
JUL 1 7 2008

Registrar DHMH 17 Rev 1/2001

24561 State of Maryland / Department of Health and Mental Hygien [] [] 8 Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10:45AM[™] **Physician** 9 2008 JULY HENRY W. LINDEMANN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** TALBOT EASTON 8806 ROUND HOUSE CIRCLE 8. Date of Birth (Month, Day, Year)
NOV. 7,1916 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Months KANSAS Yrs. 91 214-12-6742 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 27 is marked other then "neturel", or items 23e or 28e-f show treumetic event, the Medical Exambat haust be notified at 1 Yes 2 No RIDGELY Director CAROLINE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21660 11039 RIVER ROAD e filed within 72 hours after death tall Hygiene. Funera 14. Race - American Indian, 12. Was Decedent Ever in U.S. Amed Forces? 1 2 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE If Yes, Give Year or Dates: þ 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **AGRICULTURE** FARMER 0 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental by Importent: If Item 27 is marked oth any injury or other treumetic event 9DRS. Be MARIE KRACKE DIETRICH LINDEMANN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8806 ROUND HOUSE CIRCLE, EASTON, MD 21601 REGINA A. CHAPMAN/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 7/15/2008 EASTON, MARYLAND 22. Name and Address of Facili 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 上のよう MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final one week Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown spen signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 ☐ Yes 2 ☐ No 1 🔲 Yes 312 No certificate Hospitel or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director Be DAUGHTERS Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 ☐ No this RESIDENCE funeral 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: After (Month, Day 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 24 hours a Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. To the P the th 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of continue 2 TLS o completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers 5+VA

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Cynword

MD

32. Aegistrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Robert Michael Mullins July 2008 12:10 PM 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 492 Hances Point Road North East Ceci1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** XXM 2 F Months Days Hours Min. 30, Director 216-74-1557 49 1959 Delaware May Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f sh notified a 1 ☐ Yes 2K No Directo Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 492 Hances Point Road 21901 United States by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or Iter 1XXNever Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes ⊉ŒNo Specify White 3 ☐ Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Receiving and Shipping Clerk Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Van Mullins Berchie Mullins ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Van Mullins / Father 161 Thompson Drive, Elkton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July Date 17. permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 75 ☐ Other (Specify) Mayerdale Crematory 2008 Newark, Delaware 21. Signature of Frideral Service Lin 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or conceptications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 12 nKnown **Physician** Cimbusts resulting in death) Due to (or as a consequen of): /Medical Examiner Asates Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-trans Due to (or as a consequence of) P.O. Box 68760, The law requires that the death certificate be Diall mill Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year signed by the at 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 700 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy 1 Yes 2 No 1□ Yes 2 No To the Hospital or Attending Physician; filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be 2 □ Mo Other: 4 \(\text{Nursing Home} \) 1 ☐ Yes 5 Residence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) I Am eith Hen MP 16/08

Registrar

DHMH 17 Rev 1/2001

State

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who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JUI CHIH HOU, MD

31. Date filed (Month, Day, Year)

JUL 1 7 2008

State of Maryland / Department of Health and Mental Hygiene

		_	State Registrar	of Maryland	•		of Health of Death		. F	leg. No. UUU	
F	Physici /Medic	_	1. Decedent's Name (First, Middle, Last) Michael	Peter Mi	szczuk				2. Date of Dea Month July	Day Year	3. Time of Death 4:15 p M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and nu 606 Rustic Court 5. Social Security Number 6. Sex 1 M 2 □ F	7. Age (In yrs. I	as <i>t birthd</i> ay) Yrs.	if Under 1	own, or Location Perryv Year If Under Days Hours	ille er 24 Hrs.	8. Date of Birth (Month, Day Aug · 1,	9. Bir	ecil thplace (State or Foreign ountry) Maryland
	ryland how		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	eation					10d. inside City Limits
	with the Ma 3a or 28a-f s	Il Director	Maryland Cecil 10e. Street and Number 606 Rustic Court	Į		10f. Zip (Perryv Code 2190			10g. Citizen of What C	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	Armed F	edent Ever in U.sorces? 2 \(\text{No}\) No ive Dates: 1969-	s. 13. 1	Was Decede If Yes, speci 1 ☐ Yes 2	ent of Hispanic C ify Cuban, Mexic No Specif		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
1215-0036	vithin 72 hou ene. han "natura le Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Dece (Give life.	kind of worl DO NOT use	Occupation k done during me e retired) Trailer		- 1	16b. Kind of Business D & W Asso Pasadena,	ciates
d 21	filed within I Hygiene. other than " rent, the Mer	Be Co	17. Father's Name (First, Middle, Last)		110	10001				Maiden Surname)	, , , , , , , , , , , , , , , , , , ,
ylan	should be and Mental Is marked of umatic eve	To B	Frank Mitchel	ll Miszc						ary Kozik	
Maryland	permit. Pages 1 and 2 should by Department of Health and Ments Important: If item 27 is marked any injury or other traumatic es once.		19a. Informant's Name/Relationship (Type. Print) Sue Ellen Miszczuk (wife)			•			er, City or Town, State, Maryland	Zip Code) 21903
ore,	of Hea		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from	20b. P	lace of Dispo emetery, crei	osition (Nam matory or ot	e of her place)	С	Date	20c. Location - City o	r Town, State
Baltimore,	it. Pag intment intant: I injury c		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee				metery	07/1	7/08	Baltimore,	Maryland
Ba	permir Depar Impor any ir		23a. Parl 1. Enter the disease, or complications that	1000g	L. P.	ee A. erryvi	Patters 11e, Ma	on & rylan	d 2190	eral Home, 3-0766	P.A.
	Physician and /Medical Examiner is the pural-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a consequence of or a consequence or a consequence of or a consequence of or a consequence of or a consequence of or a consequence o	uence of): uence of):	ncl	<u> </u>				Onset and Death
.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and s should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	utcome pf pregna birth 2 Feta pnant at time of do nown	death 3	⊒Ectopic pre				23d. Date of d Month	alivery Day Year
rds, P.	w requires that been signed b should be deta	ρ	Part II. Other significant conditions contributing to o	death but not resu	ulting in the u	inderlying ca	use given in Par	rt I.	23e. Did to	obacco use contribute ∕es 2 □ No 3 □ F	to the cause of death? Probably 4 Unknown
Ä	The ate has page	Completed							1□ Yes	prior to rmed? death? 2 ☑ No 1 ☐ Ye	
	ding Phy J. After this funeral d	tion: To Be	27. Manner of Death 28a. Date		ER/Outpatie 28b. Time o Injury		Othor:	Nursing Ho		ne) dence 6 □Other (Sp now injury occurred	ecify)
.=	Fer	Certification:	3 Suicide 6 Could not be 28e. Place	e of injury - At ho ding, etc. (Specify	ome, farm, st	reet, factory	, office		28f. Location (8 City or Tox	Street and Number or I vn, State)	Rural Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the 2 ☐ Medical Examiner: On the and ma			nvestigation	, in my opinion, o	death occur	red at the time,	date and place, and d	ue to the cause(s)
	To 1 To 1	Σ	29b. Signature and title of certifier	le h	2.	29c	00/5	734	9	29d. Date signed (Mo	nth, Day, Year)
4	1+/WA		30. Name and address of person who completed can	=P M	0	140	9 VAL	LEY	FORG	E WAY,	ABINGDON, M
	Sta Regist		31. Date filed (Month, Day, Year) 32. JUL 1 7 2008	Redistrar's Signa	ture /	book	,			ί	21007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 24564 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Year James C. Monaghan, Sr. /Medical July 13, 2008 5:00 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1650 Saint Margarets Road Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 XM 2 ☐ F Months Days Hours 87 Director 217-07-0799 Dec. 13,1920 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland show 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examination that the Indianal and once. 10d. Inside City Limits MD Anne Arundel Annapolis Director 1 ☐ Yes 2 ▼No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1650 Saint Margarets Road 21409 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 TNo If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 Completed by 1 □Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Plumber Plumbing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) James Lester Monaghan ပ Mary Elizabeth Kammer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha E. Monaghan/ Daughter 1652 Saint Margarets Road Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 18, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery Baltimore, Maryland 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** meltoma disease or condition resulting in death) /Medical Due to fr as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the list of the cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed physician a s the burial-t Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4 Pregnant at time of death Month Year Day 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached ☐Yes 2☐No 9 Illnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIBVESTTY 1 ☐ Yes 2 🕱 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 X No 2 📈 No 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 \sum Nursing Home After this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 2 Accident 1 □Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

State

Day, Registrar

29b. Signature and title of certifier

me dely -

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peninsula

29d. Date signed (Month, Day, Year)

29c. License number

1)24768

Farm Road, Suite 3A Arnold MD

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To .	-		Registrar 1. Decedent's Name (First, Middle, Last)			Dealii	2. Date of Death	g. No	3. Time of Death
	Physicia	in	Josephine Magli	C ₁			July 10,	Day Year 2008	3:58 P M
	/Medic Examin	-	4a. Facility Name (If not institution, give street and number)		Location of Death		4c. County of Dea	th
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	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🗓 F 7. A	ge (In yrs. last birtho	Months Davs	Hours Min.	(Month, Day,) Lugust 29	(ear) 1913 Ne	ountry) Sw York
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	the N 28a-f 10tifie	rect	Maryland 10e. Street and Number	Daic	10f. Zip Code		100	g. Citizen of What C	ountry?
	3a or st be	٥	319 Broxton Road		213	212	Į	United Sta	ates
	ems 2	Funeral Director	11. Marital Status 12. Was Deceder Armed Forces	t Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto i	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
20	filed within 72 hours after death with the Maryland Hygiene. Hydiene. Inter than "natural" or Items 23a or 28a-f show int, the Medical Examiner must be notified at	y Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	No	1 ☐ Yes 2 🕅 No	Specify:		Specify:	White
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and	l be fil ntal H ed oth	Be	17. Father's Name (First, Middle, Last) Collogero Sebastian	Gibardi				a Catalan	0
	should Ind Me Imark Imatic	٥	19a. Informant's Name/Relationship (Type. Print)		Mailing Address (Street	and Number or Rura	l Route Number,	City or Town, State,	Zip Code)
<u>s</u>	alth ar		Robert Maglia / Son	319	Broxton R	oad, Balt:	imore, Ma	aryland 2	21212
e,	es 1 a of He of Item		20a. Method of Disposition 1√∆Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery,	Disposition (Name of crematory or other place	ce)		Oc. Location - City o	
Saitimor	Pag tment tant: I		4 Donation 5 ☐ Other (Specify)	Holy Cr	coss Cemete			ulver City	
ga	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Cigense)					s, MD 21401
н	121	П	23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do no line.	t enter the mode of dyir	ng, such as cardiac o	r respiratory arre	st, .	Approximate Interval Between Onset and Death
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J Ö	nat the d by tl letach	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death		the underlying cause give	ven in Part I.	23e. Did tob	acco use coptribute	to the cause of death?
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Vital Records,	s been shoul	Completed	W				24a. Was ar	24b. Were	autopsy findings available
2	sician: The law certificate has b irector, page 2 s	omo					autopsy perform 1 Yes 2	ned? death?	
<u>Ta</u>	ertifica ctor, p	Be C	25. Was case referred to medical examiner?			26. Place of Deatl	(Check only one	•)	
7	Physician: r this certifica ral director, I	은	1 Yes 2 No Hospital: 1 Inpa		batient 3 DOA			nce 6 Other (Sp w injury occurred	pecify)
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the besi and manner and manner.	s of examination and	death occurred at the t l/or investigation, in my	ime, date and place, opinion, death occur	and due to the ca	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	3	29b. Signature and title of certifier		29c. Licen	se number 064788	25	9d. Date signed. (Mo	
)	adi	1	I W	.)				7/10/0	<u>)</u>
	1,2		30. Name and address of person who completed cause of VIJAT SHARMA	death (Item 23a) (T	J. MT. ROY	AL AUF	BALTIN	CRE MO	21217
)	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Fig. 32. F	strar's Signature	Type, Print) U. MT. ROY April				1

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	Physici	an	4a per fd denot 07/16/08 dl State of Maryland / Department of Health and N 1- State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) STANLEY E. McCANN					2. Da	2. Date of Death JULY 11, 2008		Year	3. Time of Death 3:10 PM M				
	/Medio Examin		4a. Facility Name (If not institution, give	re street and number)	Pohah	vilitat	4b. City, T	own, or	r Location of Deat	th			nty of Deat ne Arun		
	Funeral Director					e (In yrs. last birthday) If Under 1 Year If Under 24 Hts. 8 OR Wre Months Days Hours Min.				. (Mo				hplace (State or Foreign untry) York		
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36	s after ", or Ite amine	by Fu	1 ☐ Never Mar 3 🖫 Widowed	ned 2 Married	ty∏Yes 2 ☐ If Yes, Give Year or Dates:	[№] 1943	-	1 ☐ Yes 2		Specify:	i io i ii oani,	0.0.7		-16	ite	
Baltimore, Maryland 21215-0036	2 hour atural		A	15. Decedent's E	ducation	_1945	16a. Dec	edent's Usual		oation during most of wo	orkina		16b. Kind o			
1215	vithin 7 ne. han "n Medi	Completed	Elementary/Seco	cify only highest gr ondary (0-12)	College (1-4or 5	5+)	life	<i>Manager</i>	e retire	daning most of we	nnig		y, mo	n Reso	read	
d 21	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Co	12 17. Father's Name	(First, Middle, Las	<u>4</u>			Minger -		18. Mother's Na	me (First,	Middle,			II Ces	
/lan			Earl W	. McCann			- Y			Bessie F						
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imo	permit. Pages 'Department of H Important: If ite any Injury or of		1 ☐ Burial 2 4 ☐ Donation	Cremation 3 5 Other (Speci	Removal from State		as Cren	natory	·	7–1	4-08		Edgewate	er. Mai	yland 21037	
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			23a. Part1. Enter	the disease, or cor	nplications that caused one cause on each li	the death	h. Do not e			ns Island ng, such as cardia				%d. 21	037 Approximate Interval Between	
	Physician		Immediate Cause	(Final	one cause on each II	C 01	Viac	^ 1	bm	Maria					Onset and Death	
7	/Medical Examiner		resulting in death)	(Due to (or as	a consequ	uence of):		- /							
	* *	er	Sequentially list co	onditions, mmediate	b Due to (or as	or as a consequence of):										
	executed in and iat-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.													
60,			resulting in death)	Last	Due to (or as	a consequ	uence of):									
6876	ifficate g phys as the	Certification: To Be Completed by Physician/Medical			_d											
Box	Attending Physician: The law requires that the death certificate be refeath. ector: After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the but		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								livery Day Year					
rds, P			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								3e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 ᡚ nknown					
Division or Vital Records, P.O.												4a. Was autop perfo		4b. Were a prior to death?	utopsy findings available completion of cause of	
/ital	cian: ertifica ector, p		25. Was case refe examiner?	rred to medical	t = 5k - t-				T 044	26. Place of De	eath (Che	ck only c	ne)			
or	Physl r this o		1 ☐ Yes 2☐ 27. Manner of Dea		Hospital: 1 Inpatie	ıry	ER/Outpati 28b. Time			41.4 Nursing			dence 6 now injury oc		ecify)	
ion	nding ath. r: Afte ie fune		Month, Day Year Injury Injury							Work?						
)ivis	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	rtific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not li determined		ury - At ho tc. (Specif							on (Street and Number or Rural Route Number, Town, State)			
		Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)									s stated. e to the cause(s)				
	To th Within To th compl	Me	29b. Signature and	dutte of certifier	Aditya C	nopra,	MD			7028			29d. Date si	_	th, Day, Year)	
	(9) Of 1		30. Name and add	ress of person who	completed cause of c	,		e, Print) MD 3	2111	\(\lambda\)		•				
	Sta	ite	31. Date filed (Mo	-	32 Regist	rar's Signa	ature	10.00	-17	01						
	Regist	ar	J	UL 1 5 20	108	2	× A	horse	_							

DHMH 17 Rev 1/2001

amend lines 4a & 28f per me aaco hlth dept 07/15/08 dlw
08-05302 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Thomas E. McLear State of Maryland / Department of Health and Mental Hygiene

2008 24567

	State of Maryland / Department of Health and Mental Hygiene 2008 2456 Certificate of Death Reg. No.								
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death			
Madical Examiner	THOMAS EDGAR McLEAR			Month D July 10, 200	8	1702 hrs			
1	4a. Facility Name (if not institution, give street and number 2823 Coxneck Road 2823 Cox N	- /	4b. City, Town, or Location of Death Chester		4c. County of Deat Queen Anne'				
Funeral		Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	. 8. Date of Birth(MM/DD/YYYY) 9. Bi	rthplace (State or Foreign			
Director	122-01-6147 1XM 2_F	89 Yrs	Months Days Hours Min.	OCTOBER	19,1918	NEW YORK			
	Usual Residence of Decedent					10d. Inside City Limits			
w any	10a. State 10b. County	10c. City, Town or Local				1 Yes 2 X No			
Maryland 28a-f sho d at once	MARYLAND QUEEN ANNE S 10e. Street and Number		CHESTER 10f. Zip Code	10g	. Citizen of What Co				
the Mar a or 28 iiffed a	2823 COX NECK ROAD		21619		UNITED ST	PATES			
s 23	11. Marital Status 12. Was Deced		as Decedent of Hispanic Origin? (Sp		14. Race - Ame	rican Indian, Black,			
r death v or item must b	1 Never Married 2 Married Armed Ford	2 No	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.				
ral", o	3 X Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X No specify: nt's Usual Occupation (Give kind of v	work dono. 1	Specify: WH				
hours "natu Exan	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) College (1-4)	during n	nost of working life. DO NOT use reti		ob. Kind of Business	mildustry			
5-0036 ed within 72 hour tygiene. other than "matu in Medical Exa	4	,	BOAT CAPTAIN		MAR	ITIME _			
5-0036 led within 7 Hygiene. to ther than the Medica	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma	iden Surname)				
21218 buld be fill Mental H marked ic event, I	WILLIAM EDGAR McLEAR 19a. Informant's Name/Relationship (Type, Print)	10h Mailir	SADIE (ang Address (Street and Number or		er City or Town, Sta	te. Zin Code)			
MD 21 d 2 should lith and Mer aumatic even	STEPHEN P. KELLEY/STEP-SO		WINDMILL POINT RO						
- F 20 E C	20a. Method of Disposition	20b. Place of Dispo	sition (Name of cemetery,	Date	20c. Location - City				
altimore, mit. Pages I a partment of He portant: If it	1 Burial 2 X Cremation 3 Removal from 4 Donation 5 Other Specify:	CENTER		Y 13, 2008	STEVENSVI	LLE, MARYLAND			
p part mit	21. Signature of Fundral Service Licensee	22. CR	Name and Address of Facility FUNE EMATION AND FUNE AD, ANNAPOLIS, M	LOWS HEI	FENBEIN A	ND NEWNAM 4 RESTGATE			
	23a. Part I. Enter the disease, or contolications that cau	M01386 RO	AD, ANNAPOLIS, M	ARYLAND 2	1401	Approximate Interval			
Physician Medical	failure. List only one cause on each line.		the mode of dying, such as cardiac .	or respiratory urres	i, shook, or hour	Between Onset and Death			
caminer	Immediate Cause (Final disease a. Contact Gun or condition resulting in death) Due to (or as a contact Gun)	shot Wound of Head onsequence of):				+			
	Sequentially list conditions, b.					-			
ted nisit Examiner	if any, leading to immediate Due to (or as a constant of the initial of the initi	onsequence of):							
χaπ , xaπ	(Disease or injury that initiated events resulting in death) Last Due to (or as a continuous description of the continuous description)	onsequence of):							
D, be executed sician and minal - transit edical Ex	d								
50, te be es ysiciar burial	UNPENDED AMENDED IF FEMALE: 23c. If yes, or	utcome of pregnancy			23d. Date of deliv	erv			
Sox 68760 leath certificate be attending physifor use as the buy ysician/Me	23b. Was decedent pregnant in the	th 2 F	Fetal death 3 Ectopic pregn	nancy	Month	Day Year			
Box (e death ce the attenced for use	1 Yes 2 No 9 Unknown 9 Unknown	books .	Other (Specify)						
O. O. Bothat the de detached f	Part II. Other significant conditions contributing to		underlying cause given in Part I.	23e. Did tob	pacco use contribute	to the cause of death?			
ires that signed a be deta				1 Yes	2 No 3 P	robably 4 Unknown			
ords, w requir s been s should				24a. Was at autops	y prior t	autopsy findings available o completion of cause of			
Records, The law requires fircate has been sig, page 2 should be Completed				perform 1 Y Yes 2					
of Vital Records, g Physician: The law require ther this certificate has been si meral director, page 2 should b n: To Be Completed	25. Was case referred to medical examiner?		26.Place of Death (Check						
Physic Physic or this or To F	1 Yes 2 No	patient 2 ER/Outpatie f Injury 28b. Time o			Residence 6 Ot ow injury occurred	her: Scene			
n of ding Ph. : After t e funeral	1 Natural 5 Pending FOUND:	Day, Year) FOUND:	1 Yes 2 ✓ No	Subject shot					
Division o ital or Attending us after death. ral Director: Aft lled in by the fure ertification:	2 Accident Investigation Jul 10, 20		reet, factory, office building, etc.	28f. Location (S	treet and Number or	Rural Route Number, City			
Divi	Julian Salara	Driveway		or Town, St 2-23 Cowneck	ate) ZOZ3 CQ Hond, Shostor, M	Chester, MD			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burifledical Certification: To Be Completed by Physician/Med	29a. Certifier 1 Certifying Physician: To the best one) 2 Medical Examiner; On the basis of	examination and/or investig	curred at the time, date and place, argation, in my opinion, death occurred	nd due to the cause at the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)			
To wit	29b. Signature and title of certifier	A CONTRACTOR OF THE CONTRACTOR	29c. License number		29d. Date signed (Month, Day, Year)			
, and	(alunn	2/ (-	O.C.M.E.		July 11, 2008				
(X)	30. Name and address of person who completed cause		onn Ctroot Baltimara MD 0	1201					
1 175	Zabiullah Ali, M.D. Assistant Medica 31. Date filed (Month, Day, Year) 2000 32. Re	strar's Signature	enn Street, Baltimore, MD 2	1201		<u> </u>			
State Registra	1 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Com &	parte		·				
DHMH 17 Rev 1/2001		ORIGIN	AL	20100	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 29 Day 2008 Year **Physician** Joseph R. MacIsaac 8:35а м /Medical 4a. Facility Name (If not institution, give street and number) Washington Adventist 4c. County of Death 4b. City. Town, or Location of Death Examiner Takoma Park Montgomery Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Month, Pay, Year) 7 / 27 / 1927 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 220-32-5450 1 XM 2 □ F Months Days Hours Min. 80 Cănáda Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits show 10a State 10b. County event, the Medical Examiner must be notified at MD Director Montgomery Silver Spring 1 ☐ Yes 2 🔼 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 321 University Blvd.West #128 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 72 hours after 1 Never Married 2 Married 0 1 ☐ Yes 2 🕱 No Specify: White þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Salesman Insurance Co. permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien-Important: If item 27 is marked other the any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Peter MacIsaac Mary MacDonald ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 University Blvd.West #128 Silver Spring
te of Disposition (Name of Date 20c. Location - City or Town, State Frances MacIsaac/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 7/02/2008 Beltsville, Md 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service License PHILIPADSRINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myelodysplasia /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): physician Physician/Medical the attending pl 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ned by the a ☐Yes 2☐No 9 Unknown 9 I Unknown been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ heart failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 Yes 2 No certificate 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No Hospital: Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗌 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the death certificate be executed P.O. Box 68760, Division of Vital Records, The law requires Hospital or Attending Physician: eral Director: After the filled in by the funeral 24 hours after death e Funeral Director: completely within 2 To the I the

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kashif Firozvi MD

29a. Certifier

ical

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

16 JUL



2101

and manner stated.

Medical Center Dr. #200 Silver Spring, Md

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0064983

29d. Date signed (Month, Day, Year)

မ

1 - For State Registrar

State of Maryland / Department of Health and Mental Hygien 008

en2008 24569

			I = State Registrar Certificate of Death Reg. No.									
	Dhusis	40.	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death	Date of Death Month Day Year 3. Time of Death			
	Physici /Medi		Vernon	Lewis May	nard			July	12, 2	8008	11:15A M	
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Loc	ation of Death		4c. County	of Death		
			4871 St Barnabas Road, #2T Temple Hills							P.G.		
	Funeral Director		5. Social Security Number 6. Se 577-02-5815 Usual Residence of Decedent	7. Age (In yr.	s. last birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2-5-6	9. Birthplace (State or Foreign Country) Wash. D.C.			
	land w		10a. State 10b. County	10c. (City, Town or Loc	ation				100	d. Inside City Limits	
036	he Marylan :8a-f show ctiffed at	ector	MD. P.G		Temple						1 ∳ Yes 2 □ No	
	23a or 2	ral Dire	10e. Street and Number 4871 St Barna	bas Road,	#2T	10f. Zip Code 20748		10	g. Citizen of W		y?	
	within 72 hours after death with the Maryland nne than "natural", or Itams 23a or 28a-f show in Medical Exanding must be redified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	/as Decedent of Hispa Yes, specify Cuban, M ☐ Yes 2€ No Si	nic Origin? (Spe Mexican, Puerto <i>pecify:</i>	ecify Yes or No- Rican, etc.)	Blac	e - America k, White, et : Bla	tc.	
5-0	72 ho	etec	15. Decedent's Ed (Specify only highest grad	ucation de c <i>ompleted)</i>	(Give k	ent's Usual Occupation	n ng most of worki	ng 1	16b. Kind of Business/Industry			
Maryland 21215-0036	d within giene. ar than	Sompl	Elementary/Secondary (0-12) College (1-4or 5+) Unemployed									
	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. If Itan 27 is marked other then "natural", or Itams 23s or 28s-f show other traumatic event, the Medical Exercine at most be notified at	To Be (17. Father's Name (First, Middle, Last) Vincent Mayn	ard		18.		(First, Middle, M	aiden Sumam	e)		
			19a. Informant's Name/Relationship (T			Address (Street and St Barna						
ē,	s 1 and f Health itam 27 othar tr		20a. Method of Disposition		Place of Dispos	ition (Name of		ate 2	Oc. Location -	City or Tow	n, State	
Baltimore,	Page ent o nt: If		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		atory`or other place) e Memoria	1 7/18	1/08	aldor	f, M	ld.	
	permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar tr once.		21. Signature of Funeral Service Licens	Hacket A	22.	Name and Address of Hackett's 314- Upsh	Facility Funer	al Cha	pel,]	inc.		
l Records, P.O. Box 68760,	Certificate be executed unding physician and horial-transit use as the burial-transit	Physician/Medical Examiner	23a. Part There the disease, or components, or heart failures. List only components are conditionally continued and conditions are conditionally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consect. squence of):	r the mode of dying, su 1 YOCAR 2 d ATH	DIAL	IN	FARC	TION	Approximate nterval Between Onset and Death		
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tel death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery	/ Day Year	
	56 50	by	Part II. Office significant continuous contributing to death but not resulting in the underlying cause given in Part I.									
		Completed	Chronic f	Heial F	iler	illat	ion	24a. Was an autopsy perform	ed? p	rior to comp eath?	sy findings available pletion of cause of	
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? 1. Types 2R No. Hospital: Check only one)									
Division of	ing Phys After this uneral di	tlon: To	27. Manner of Death 1 Street Production of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Street Course from Street Production of Street Productin									
	or Attanding after death. Director: After d in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 1 Homicide 1 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Place of Injury - At home, farm, street, factory, office City or Town, State)								Route Number,	
	Hospita 4 hours Funaral ely fillec	edical C	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exem	sician: To the best of my kr iner: On the basis of examinand manner stated.	nowledge, death nation and/or inve	occurred at the time, destigation, in my opinio	late and place, a	and due to the cau ed at the time, dat	use(s) and mai e and place, a	nner as stat and due to the	ed. he cause(s)	
	Vithin 2 To the Complete	Me	29b. Signature and title of certifier	QUO. Pa	M	29c. License nu	mber 4549		d. Date signed	(Month, Da	iy, Year)	
	1		30. Name and address of person who c	ompleted cause of death (Ite	em 23a) (Type, P				1 1			

Registrar

State

Yudh V. Gupta, M.D.
31. Date filed (Month, Day, Year)

JUL 16 2008

DHMH 17 Rev 1/2001

ORIGINAL

106 Irving Street, N.W.; Washington, D.C. 20010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 24570 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** Month 11:20 P M GERALDINE MCLEOD July 10, /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery HOLY CROSS HOSPITAL Silver Spring 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth 04-02-1922 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Months Days Hours 219-90-7598 86 Director Panama City Usual Residence of Decedent 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar mass be routified at Prince George's District Heights Director Maryland 1≰ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with USA 1921 Tanow Place 20747 death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel 1 ☐ Never Married 2 1 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Private Industry Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Susan St. Luz Federico McSween ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1 and 2 s Health ar Pages 1. Tent of Hea t: If item 2. 104 Crystal Spring Drive Ashton, Maryland 20861 Susana Phillips/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or once. 1 월 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-15-2008 Suitland, Maryland Cedar Hill Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MOI246 Lack A. Wel Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician _{a End Stage Renal Disease} disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed Hypertension Exami burial-transi resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical Congestive Heart Failure IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 🗷 No the 9 Unknown 9 D Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 1 □Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1∐ Yes 2 🖼 No this (1 npatient Certification: To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. nours after death.
neral Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature 29c. License number 29d. Date signed (Month, Dav. Year) D62520 07-11-2008 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Maria D'Arbella,

2008

MD

1500 Forest Glen Road

Silver Spring, Maryland 20910

ye

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
JUL 1 7 2008

Ronald C. Wheeler, M.D. 1221 Mercantile Lane Largo, MD 20721

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

1 6 2008

JUL

	-	For State Registrar		State	of Marylar		artment of H		nd Menta		ne No.20	08	24573	
Physicia /Medic	_	1. Decedent's Name (First, Middle	. ,	LSS				2. Date Mor	e of Death	Day //	Year 8	3. Time of Death	
Examin	er	4a. Facility Name (If no	ot institution M 04	n, give street and no MACYLA	AND MES		4b. City, Town, or BAC	TIME	DRE		4c. County			
Funeral Director		5. Social Security Num 233–30–864 Usual Residence of De	44	6. Sex 1 □ M 2 X F	7. Age (In yrs. 85	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Mo	e of Birth nth, Day, Yea		Cour	place (State or Foreign otry) VIRGINIA	
land ow	ŀ		0b. County		10c. Ci	ity, Town or Lo	cation					1	I0d. Inside City Limits	
72 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	ţo	MD	7	TALBOT		EAST	ON						1 ☐ Yes 2 XNo	
r 28a	Director	10e. Street and Numb	er				10f. Zip Code			10g.	Citizen of	What Cour	ntry?	
h with		30093 MA	PTHEWS	STOWN RD.			2	1601				USA	ı.	
deat	Funeral	11. Marital Status			cedent Ever in U	J.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Orig	in? (Specify Ye	s or No-		ce - Americ		
after or ite		1 Never Married	2 ☐ Marı		2 X No		1 ☐ Yes 2 🕱 No	Specify:	r derio riiodii, c	310.)	Specif		eic.	
ours iral",	d b	3 Widowed 4	Divorced	Year or l						-		MHT		
72 h "natu dical	Completed	1! (Specify	 Deceden only highe 	t's Education st grade completed)	i (Give	dent's Usual Occup kind of work done o	durina most	of working	16b	. Kind of B	usiness/In	dustry	
vithin sne. than	m d	Elementary/Second	ary (0-12)	College 0	(1-4or 5+)		OO NOT use retired ASHIER	1)			DETA	IL SI	งางส	
e filed within 72 al Hygiene. I other than "na vent, the Medic		17. Father's Name (Fi	rst Middle			\ CE	SHIEK	18. Mother	's Name (First,	Middle, Maid			.ORE	
	o Be	SAMUEL SA		Lusty					LLA THON		ion ouman	110)		
2 should be and Menta is marked raumatic ev	ř	19a. Informant's Nam		hip (Type, Print)		19b. Mailir	ng Address (Street				tv or Town	. State. Zic	Code)	
nd 2 s Ith ar 27 is trau		LAWRENCE :					3 MATTHE			•			,	
of Health of Health item 27 i	0 =	20a. Method of Dispos		JOJ DOR	20b.	Place of Dispo	sition (Name of		Date			- City or To		
Pages nent of l nt: If its		1 □ Burial 2 X 0 4 □ Donation 5		3 □Removal from	n State		matory or other place	i i	mo 7/15	/2008	टक्क	WMCV	TILLE, MD	
permit. Pages 'Department of Himportant: If ite any Injury or ot		21. Signature of Fune		Licensee			Name and Addres	ss of Facility	BEIN & N	IEWNAM	FUNE	RAL E		
		23a Part1 Enter the	O Z		CERO		00 S. HAR				MD 2	1601_	Approximate	
		shock, or heart failure. List only one cause on each line. Inferval Between Onset and Death Immediate Cause (Final												
Physician		disease or condition resulting in death)	nai	_aCD	RONA		KOMBOS	IS					50 MENS_	
/Medical Examiner		, , , , , , , , , , , , , , , , , , , ,		Due to	o (or as a conse	quence of):	0 000	7	ESEASE				V6175	
No.	<u></u>	Sequentially list condi	itions,	b. Due to	(or as a conse	guence of):	RY ARTE	by D	F75425				1 CARS	
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be executed ician and burial-transit	xar	that initiated events resulting in death) Las	st	c	o (or as a conse	quence of):			-					
	edical			d										
law requires that the death certifical as Leen signed by the attending p 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent p	roanant		utcome pf pregr						23d. Da	ate of delive	erv	
atter 1 for 1	ciar	in the past 12 m	onths?		birth 2 ☐ Fet nant at time of		∃Ectopic pregnancy ∃ Other (specify)	/				onth	Day Year	
that the de led by the a	ıysi	1 ☐ Yes 2 🔀 1 9 ☐ Unknown	40	9□Unk	nown									
es that igned b		Part II. Other significa	ant conditi	ons contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part I.	23	e. Did tobaco	co use con	tribute to t	he cause of death?	
quires n sign ald be	d by	SEVERE	PUL	MONARY GURGIA	HYPER	TENSI	9N			1 Yes	2□ No	3 ☐ Prot	bably 4 □Unknown	
w requii	Completed	MTARAL	RE	GURGIA	ATTON	J			24	a. Was an	24b.	Were auto	ppsy findings available	
, 9 7 6 1	ш	DEOTOIL	101	VASCU					_ _	autopsy performed	1?	prior to co death?	impletion of cause of	
ician: Th certificate ector, pag		25. Was case referred	d to medica		CFITC	1) 200	100	26 Place	of Death (Chec	Yes 2	No	1 □ Yes	2□ No	
Attending Physician: rdeath. ector: Affer this certific by the funeral director,	o Be	examiner?		Hoenital:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	er.	rsing Home 5		- 6 □Otl	har (Spaci	60	
g Phys er this eral dii		27. Manner of Death		28a. Date	e of Injury	28b. Time o				scribe how i			<i>y/</i>	
nding tth. :: Afte	ıt lo	1 ☑Natural 2 ☐ Accident	5 Pendir investi	19 1 '	nth, Day Year)	Injury		κ? Yes 2 □ N	10					
Atter r dea ector	if Co	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	pined 286. Plac	ce of injury - At h	nome, farm, str	eet, factory, office		28f. Loc	ation (Stree	t and Num	ber or Rura	al Route Number,	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	- Плотногов		Dull	ding, etc. (Spec				City	y or Town, S	iaio)			
bspit hour inera ly fille		29a. Certifier 1		og Physician: To the										
he He in 24 he Fe	edical	oney 2	Medical	Examiner: On the and ma	nner stated.		vestigation, in my c	opinion, dead	occurred at B	ie time, date	апи ріасе	, and due t	o trie cause(s)	
To t	Ž	29b. Signature and tit	le of certifie	er .			29c. Licens	e number	1116.	29d.	Date signe	ed (Month,	Day, Year)	
(4		1/ 1	X.	W			1000	64 1	77		17/1	1/20)O8	
0		30. Name an indo es	s of perion	who completed car										
KK		PETER	A.	REYES	MD	<u>22.</u>	S. GRES	ENE :	ST BA	CIJMO	RE N	ND 2	1061	
Sta		31. Date filed (Month,	Day, Year)	6 2008 32	egistrar's Sign	nature								
Registr	ar	J	OF I	0 2000	there .	M A								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2008 Shon July Jae Kap 4:52 A^M 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Montgomery 01nev 8. Date of Birth (Month, Day, Year) March 7,1924 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral Months Davs Hours Min. 1 ☑ M 2 □ F South Korea 219-88-9949 84 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Director 1 Yes 2 □ No MD Montgomery 01ney 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20832 2100 Olney Sandy Spring Road, #303 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify 3 Specify: Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, It. Mydic once. Elementary/Secondary (0-12) College (1-4or 5+) Electrician Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kyoung When Shon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonya Lee - Daughter 2100 Olney Sandy Spring Rd., #303 Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory July 15,2008 Beltsville, MD 21. Signature of uneral Service Licenses 22. Name and Address of Facility Sanders & Son Mortuary Service 7908 Kincannon Pl., Lorton, VA 26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Neumonia **Physician** /Medical Due to (or as a consequence of): **Examiner** EXACERBATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Exami and Due to (or as a consequence of) P.O. Box 68760 attending physician the death certificate be Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Po Month Day Year 5 ☐ Other (specify) □Yes 2□No detached he 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No. 24a. Was an autopsy 22 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Prince PHILIP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLNERMO 31. Date filed (Month, Day, Year) State 2008 16 Registrar

7/16/08pgcbcj Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-05374 2008 24575 State of Maryland / Department of Health and Mental Hygiene Krishna Harbowe Seegobin 1-For State AMENDED#18&19aperpa Certificate of Death Reg. No. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 13, 2008 1550 hrs ¬I Examiner Krishna H. Seegobin c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore St. Agnes Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex **Funeral** Days Hours Months 3/13/1979 Country) Guyana Director 29 1X M 2 F 121-86-1916 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County II. 1 X Yes 2 No Silver Spring 28a-f show 23a or 28a-f show notified at once. Maryland|Montgomery death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 Guyana 11404 December Way #102 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. or items Armed Forces? 2 Married 1 X Never Married 2 X No Yes ä Specify. Indian 1 Yes 2 X No specify: f Yes. Give Year . Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 3 Widowed 4 Divorced item 27 is marked other than "natural", r traumatic event, the Medical Examiner ò 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Private Maintenance Technician 21215-0036 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Coolball Be Selochanie L. Koma1 Seegobin (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ooblall cooblal Coolball/Mother 8103 New Hampshire Ave, #4, Hyattsville, MD 20783 Saltimore, MD Selochanie L. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition

1 Burial 2 X Cremation 3 crematory or other place) Removal from State Fort Lincoln Crematory 7/21/2008 Brentwood. Maryland Donation 5 Other Specify 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licenses 20722 3401 Bladensburg Rd., Brentwood, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Death **fledical** a Multiple Blunt Force Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical AMENDED UNPENDED ysician burial -23d. Date of delivery Box 68760 23c, If yes, outcome of pregnancy IF FEMALE: signed by the attending phy be detached for use as the b Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 ✔ No 3 Probably 4 Unknown ò Completed 24b. Were autopsy findings available Division of Vital Records, 24a. Was an has been s prior to completion of cause of autopsy performed? death? 1 V Yes No No ✓ Yes 2 page certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be Other₄ Hospital: Nursing Home 5 Residence 6 Other: examiner? Inpatient 2 ER/Outpatient 3 this 1 Yes No ۵ 2 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Driver of motorcycle struck wall, fell from Certification: Jul 13, 2008 1534 hrs 1 Yes 2 ✔ No 1 hours after death.

uneral Director: A
ly filled in by the fu Natural overpass, then struck by other vehicles 5 Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 or Town, State) I-895 & I-95, Arbutus, MD Suicide determined (Specify) Major Road / Highway 24 hours a Funeral I Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Wedical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 14, 2008 O.C.M.E. 11 M 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Russell Alexander MD. 1. Date filed (Month Day Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 OCMF 2006

Registra

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08-05	387
Gary :	Smith

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State of Manyland / Department of Health and Mental Hygiene

ary Smith		State 1- For State	of Maryland / Depa	rtment of F tificate of L			200	8 2451
Physicia	_	Registrar 1. Decedent's Name (First, Middle,La:		uncate or L	- Catri	2. Date of De		3. Time of Death
ledical Examin	112	Gary Smi	•			July 13, 2	Day Year 2008	1954 hrs
		4a. Facility Name (if not institution, give			City, Town, or Location of I	Death	4c. County of Death	
		Fort Washington Hospital			Fort Washington	Allen I Poto of P	Prince George	
Funeral Director		5. Social Security Number 6. S	, ,		If Under 1 Year If Under 2 Months Days Hours	Min.	Co	untry)
Billottoi	-	579-84-1217 15 Usual Residence of Decedent	XM 2 F 49	Yrs.		Dec 24	4, 1958 Was	hington, DC
any	1	10a. State 10b. County		Town or Location				10d. Inside City Limits
*	ے	Maryland Prince	George's Si	uitland				1 X Yes 2 No
Aaryland	Director	10e. Street and Number	<u> </u>		0f. Zip Code		10g. Citizen of What Cou	
3a or		3363 Southern A	venue		20746		United Sta	tes
th with	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces?		Decedent of Hispanic Origin , specify Cuban, Mexican, F		Io- 14. Race - Amer White, etc.	ican Indian, Black,
er dea			1 Yes 2 No	1 Y	es 2 v No specify:		Specify: B	lack
urs aft tural'	à A	15. Decedent's Education (Specify of	or Dates:	16a. Decedent's	Usual Occupation (Give kir		16b. Kind of Business/	Industry
72 ho n "na al Ex	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ĭ	t of working life. DO NOT us			
vithin ene.	Comple		4 years	Energy	Management Sp		Governm	ent
filed THyging of oth	ပ္တု	17. Father's Name (First, Middle, Las Ridgeway L. Sm	'		18.Mother's	Name (First, Middle Mary Beri	, Maiden Surname) nice Harvey	
212 Jid be Menta mark	To Be	19a. Informant's Name/Relationship (19b. Mailing A	ddress (Street and Numb			e, Zip Code)
AD 2 sho 27 is amatis		Ridgeway L. Smi	th - Brother	4166 S	uitland Road	Suitland	, MD 20746	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3		Place of Disposition	on (Name of cemetery,	Date	20c. Location - City or	Town, State
Pages nent of	,	4 Donation 5 Other Specific	Mot	unt Óliv	et Cemetery	July 19,	2 0 08 Washin	gton, DC
Salti rmit. epartm nports jury o	Ì	21. Signature of Funeral Service Dice		22. Nai	ne and Address of Facility	Stewart	Funeral Home	, Inc.
	4	23a Part I. Enter the disease, or com	allocations that sourced the death	Do not enter the	01 Benning Ro	oad NE W	ashington. D	C 20019 Approximate Interval
Physician /Medical		I ailure. List only one cause on e	ach line.	. Do not enter the	mode of dying, such as car	diac of respiratory a	ricst, shock, or heart	Between Onset and Death
xaminer	- 1	Immediate Cause (Final disease or condition resulting in death)	Multiple Injuries Due to (or as a consequence of	of):			_	
		Sequentially list conditions,						
	<u>[</u>	if any, leading to immediate	Due to (or as a consequence of	of):				
=	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):				
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ox 68760, anth certificate be ex attending physician for use as the burial	Medical	UNPENDED	AMENDED				Looi Dir. (11)	
876 tificate ng phy as the	튑	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg		death 3 Ectopic	oregnancy	23d. Date of deliver Month	y Day Year
Box 687 death certific he attending p	sicia	1 Yes 2 No 9 Unknow	4 Pregnant at time of de	n a th	r (Specify)		i i	
D. Bc	Physician/	Part II. Other significant conditions	9 Ulkilowii	esulting in the un	derlying cause given in Part	1 23e. Dio	tobacco use contribute to	the cause of death?
ries that t signed b	2	Tart ii. Other significant conditions	contributing to death but not i	esalang in the en	seriying sease given in rain		res 2 ✓ No 3 Pro	
rds, require been sig	Completed					24a. Wa		utopsy findings available
Records, The law require ficate has been si, page 2 should t	ď					per	formed? death?	completion of cause of
tal Rection: The certificate		25. Was case referred to medical			26.Place of Death (C		3 2 No 1 V	es 2 No
Vita	Be		Hospital: 1 Inpatient 2	ER/Outpatient	[Othor:	Nursing Home 5	Residence 6 Othe	er:
of Vitaling Physician After this certi	일:	27. Manner of Death	28a. Date of Injury (Month, Day Year) Jul 13, 2008	28b. Time of Inj	ury 28c. Injury at Work?		e how injury occurred st in collision with a	uto
ion trendi leath. for: /	탏	1 Natural 5 Pending 2 ✓ Accident Investiga		1920 hrs	1 Yes 2 🗸 1	No IVIOLOTOYCII	Still Complete With C	
Division ral or Attendirs after death.	Certification:	3 Suicide 6 Could no	t be 28e. Place of Injury - At h		factory, office building, etc.	or Town	(Street and Number or R , State)	
Di ospital hours a nneral I		4 Homicide determine 29a. Certifier 1 Certifying Physic	19700077 Local Site					Creek Road, Fort Wash
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	<u>ica</u>	(Check only	cian: To the best of my knowled er:On the basis of examination a					
To with	Medical	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (M	onth, Day, Year)
		1 Brandis	o MA		O.C.M.E.		July 14, 2008	
(12)		I name and address of person who	completed cause of death (Iten	n 23a)				
Syc			stant Medical Examiner		Street, Baltimore, MD	21201		
Sta Regist		31. Date filed (Month, Day, Year) JUL 1 7 2008	32. Registrar's Signat	ure				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Irene M. Sinclair AM^{M} 2008 July 10 2:00 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Genesis HealthCare -The Pines Talbot Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. 8 - 1 2 - 1 9 1 1 7. Age (In yrs. last birthday) 96 vrs Social Security Number 213-22-5732 Birthplace (State or Foreign Country) 1 □ M 2 F Months Bozman, Md Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Talbot Easton 1 X Yes 2 □ No Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 Dutchmans Lane 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sewing Factory Garment 9 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Alvin McQuay Mollie Steilkie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheridan Schultz (daughter) 108 Spencer Ave., St. Michaels, Md.21663 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 7-11-2008 Dover, De. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility R. Carroll Hurley Funeral Home, PC P.O. Box 518, St. Michaels, Md. 21663 23a. Part1. Enter the disease, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or is a consequence of) 12 10ds-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a corn equence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner be executed attending physician for use as the buris The law requires that the death certificate Box (o ۵ Records, , page 2 Division or Vital

certificate funeral director,

Physician

/Medical

Examiner

Director

Funeral

9

Completed

Be

Examiner

Physician/Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Eximiner must be notified at

Baltimore, Maryland 21215-0036

Sinclair

Completed by Be Medical Certification: To or Attending within 24 hours a TLS 2

									·	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No					
	Was case reference examiner?	red to medical		26. Place of Death (Check only one)												
	examiner? 1 ☐ Yes 2 ☐	No	Hospital	i 1	☐Other (Specify)											
	Manner of Deatl 1	5 ☐ Pending investigation		. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes 2 ☐		3d. Describe how injury	y occurred					
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of injury - At h building, etc. (Speci	ome, farm, stree	et, fact	8f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a	a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exam	n iner: Or	To the best of my kno	owledge, death o ation and/or inve	occurr	ed at t	he time, date a my opinion, de	and place, areath occurre	nd due to the cause(s) d at the time, date and	and manner as stated. place, and due to the cause(s)					

29b. Signature and title of cer

29c. License number

29d. Date signed (Month, Day, Year)

ROBINS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20

21804

State Registrar

ton Thomas		1- For State	e of Marylar		rtment of tificate of			Mental	Hygiene	Reg. No.	20	08 2457
Physicia	an/	Registrar 1. Decedent's Name (First, Middle, I Milton Thoma	ast)						2. Date of Di Month	eath Dav	Year	3. Time of Death 1640 hrs
dical Exami	ner	4a. Facility Name (if not institution,		iber)	4	b. City, T	own, or Lo	ocation of D	July 10,	2008	c. County of Deat	
		Prince George's Hospita	-			Cheve				ı	Prince Georg	e's
Funeral Director		5. Social Security Number 6. 579-84-0158	Sex 7	. Age (In yrs. la	st birthday)	If Unde	er 1 Year Days	If Under 24 Hours	Min.	,	Fore	rthplace (State or
Director		Usual Residence of Decedent	X M 2 F	47	Yrs.				May1	,19	61 C	ountry)WashDC
any	l	10a State 10b County		10c. City,	Town or Location	on						10d. Inside City Limits
land f show	ō									10.00		1 XYes 2 No
ith the Maryland 23a or 28a-f show any notified at once.	Director	6807 Forbes B	lvd.			10f. Zip 20	706			U U	S.A.	untry?
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or iten	Funeral	1 X Never Married 2 Marr	1 Yes	ces?					uerto Rican, etc.)		White, etc. Specify: Bla	ack
ırs afte ural",	ð	3 Widowed 4 Divor	or Dates: y only highest grade	completed)	16a. Decedent		X No Occupatio		d of work done	16b.	Kind of Business	
72 hou ra "nat	letec	Elementary/Secondary (0-12)	College (1-	1 == 51)				nt O	e retired) perator	. _P	rivate	Company
within grene.	Completed	17. Father's Name (First, Middle, L	201)				_		Name (First, Middl	.		
215- be filed ntal Hy ₁ ked of	Be C	Milton Thom							ara E.			
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed witbin 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	To	19a. Informant's Name/Relationshi Linda Wright	(Type, Print) - Siste:	2	19b. Mailing 6807	Address Fo	Street	and Number	r or Rural Route N d • Lanha	n , M	City or Town, Sta d。 2070	te, Zip Code)) 6
re, N 1 and f Health f item er trau		20a. Method of Disposition 1 XBurial 2 Cremation	3 Removal fro	20b. F	Place of Disposi crematory or oth SUTTEC	ition (Nar	ne of cem	etery,	Date 08	20c	. Location - City	
Fages ment of tants or oth		4 Donation 5 Other Spe	cify:	Re	_				- •	- 1	linton	
Ball permit Depart Impor injury		21. Signature of Funeral Service Li	E 120	bur	2				ral Hom			. 20001 n St.NWWash
Physician /Medical		23a. Par I. Enter the disease, or confair in List only one cause of	n each line.		Do ont enter th	ne mode	of dying, s	uch as card	liac or respiratory	arrest, sl	hock, or heart	Approximate Interval Between Onset and Death
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876(tificate ng phy- as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, o	utcome of preg		tal death	3	Ectopic p	regnancy	2	3d. Date of delive Month	ery Day Year
Box 68760, death certificate be the attending physic of for use as the bur	Physician/N	1 Yes 2 No 9 Unkn	al a make	ant at time of	5 Ot	her (Spe	cify)			- 1		
O. B. It the de by the lached f		Part II. Other significant condition		death but not re	esulting in the u	ınderlying	g cause gi	ven in Part I	I. 23e. D	id tobacc	o use contribute	to the cause of death?
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of Vital Records, ag Physician: The law require the take this certificate has been sineral director, page 2 should b	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital:	patient 2 🗸	ER/Outpatient	pr		Othor:	heck only one) Nursing Home 5	Resi	dence 6 Oth	ner:
Jof V	-	27. Manner of Death	28a. Date of Month.	of Injury Day Year)	28b. Time of I	njury		y at Work?	Subject s	ibe how i	njury occurred	leeing from police
Sion Mttendi death. ctor:	atio	1 Natural 5 Pendir 2 ✓ Accident Investi	gation	-	1601 hrs			es 2 V N	0			
Division pital or Attendio ours after death. teral Director: /	Certification:	3 Suicide 6 Could 4 Homicide determ	not be	of Injury - At he Local Stree		et, factory	у, опісе ві	Jilaing, etc.	or Tow	m. State)		Rural Route Number, City eat Pleasant, MD
Hospi 24 hou Funer tely fil		00 - 0 - 400	sician: To the bes	of my knowled	ge, death occur	rred at the	e time, dat y opinion.	te and place	e, and due to the	cause(s)	and manner as s	lated.
To the within 7 Complete	Medical	29b. Signature and title of certifier	and manner st				c. License				d. Date signed (A	
(4)		16/11/1	1				O.C.N	Λ.E.		Ju	ily 11, 2008	
No		30. Name and address of person v				m C4=	- E D. W	mor- Mr	21201			
_gc			ssistant Medic			ın Stree	et, Baltii	more, Mi	J 21201 —————			
S	tate	31. Date filed (Mooth, Day Year)	32. NO	gistrar's Sign it								

OCME

68760, Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

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		1 - State of Maryle State of Maryle Registrar	and / [Department of H Certificate of I			jiene _{leg. No.} 2 (800	24579
Physici /Medic		1. Decedent's Name (First, Middle, Last) John P. Wootten, Jr.				2. Date of Dea Month	Day	Year 008	3. Time of Death
Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number) Satisbury Rehab & Nursin 5. Social Security Number 6. Sex 1 M 2 F 52		r. Sali:	Location of Death DUCU If Under 24 Hrs. Hours — Min.	8. Date of Birth (Month, Day 12/11/	4c. County	of Death	i CC
laryland show ed at		Usual Residence of Decedent	City, Tow	n or Location				10	d. Inside City Limits
the Mary 28a-f sh notified	Director	MD Dorchester 10e, Street and Number	Gales	stown 10f. Zip Code			log. Citizen of	What Countr	1 ☐ Yes 2 ☐XNo
ath with s 23a or ust be	ral Di	5939 Wheatley Church Rd.		N/A			US		la Car
be filed within 72 hours after death with the Maryland ital Hygiene. Additional action that Hygiene. Additional Examiner must be notified at event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ₺ Divorced 12. Was Decedent Ever i Armed Forces? 1 □ Yes 2 ₺ No If Yes, Give Year or Dates:	n U.S.	13. Was Decedent of H If Yes, specify Cubs 1 □ Yes 2 ☑ No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - America ck, White, el	
in 72 hor n "natur fedical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	durina most of worki	ing	16b. Kind of B	usiness/Indu	istry
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lid be fil lental H ked ott	To Be	17. Father's Name (First, Middle, Last) John P. Wootten, Sr.			18. Mother's Name	•		ne)	
12 shouh and Mand Mand Mand Mand Mand Mand Mand		19a. Informant's Name/Relationship (Type. Print) Kimberly Owens / sister	1	o. Mailing Address (Street)	and Number or Rura	al Route Numbe	r, City or Town,		Code)
os 1 and of Healt item 2	1 1	20a. Method of Disposition 20	b. Place o	f Disposition (Name of ery, crematory or other place	; [Date	20c. Location		n, State
permit. Pages Department of Important: If it any injury or o once.		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of heral Service Licensee		22. Name and Address	y 7/16	urbage		Home	1D
Physician /Medical Examiner but sthe prival-transit sthe prival-transit	lical Examiner	23a. Part1. Enter the disease, or complications that have determined the cancer of heart failure. Let only one cause in ach line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a condition or cause) Due to (or as a condition of the cause of the cause) Due to (or as a condition of the cause) Due to	sequence sequence	of):	ig, such as cardiac d	or respiratory an	rest,		Approximate interval Between Onset and Death
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Physiciar this certifial	To Be	25. Was case referred medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 □ ER/O	utpatient 3 DOA Oth	er: 4 A Horsing Ho		ne) lence 6 □Ott	ner (Specify)	
Attending r death. ector; After by the funer	Certification:	27. Manner of Death 1	At home, fa	Time of Injury Mor M 1 arm, street, factory, office	Yes 2 □ No	28d. Describe h 28f. Location (S City or Tow	Street and Numi		Route Number,
the Hospital or nin 24 hours afte the Funeral Dir npletely filled in		29a. Certifier 1 Certifying Physician: To the best of my	knowledg	e, death occurred at the tir	me, date and place,	and due to the	cause(s) and m	anner as sta	ited.
To the Ho within 24 I To the Fu completel	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated. 29b. Signature and title of certifier	mination ar	nd/or investigation, in my o			date and place, 29d. Date signe		
->-0		· Mahm		0	2538	5	7/1	78	
E.T 4	to	30. Name and address of person who completed cause of death (William H. Robins, M. 1 31. Date filed (Month, Day, Year) 32, Registrar's S	1 2	om Civia	. Ave. S	alisbu	ry, r	D	21804
Regist		JUL 1 7 2008	#	porte					

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 For State Registra 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 008 16:30 PM July 16 Physician SAVANNAH MAE WALKER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A**Baltimore City** The Johns Hopkins Hospital 8. Date of Birth July 15, 2008 9. Birthplace (State or Foreign If Under 1 Year If Under 5. Social Security Number Age (In vrs. last birthday) MARYLAND Days Min **Funeral** Hours 23 Yrs. N/ADirector Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10h County 10a State er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No N/ADirector N/AN/A 10g. Citizen of What Country? 10f, Zip-Code 10e. Street and Number U.S.A. N/AN/Apermit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must be Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: \$ White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) N/A N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LINDA JO KREIGLINE RONALD L. WALKER ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 15 DOGSTREET ROAD, KEEDYSVILLE. 21756 MARYLAND RONALD L. WALKER, PARENT 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/19/2008 STAUFFER CREMATORY FREDERICK, MARYLAND 4 Donation 5 Other (Specify) 21. Signature Fury ra Service Licensee 22. Name and Address of Facility Bast-Stauffer Funeral Home, P.A. Parl 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate 23a, Par 1. Respirator Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Prematurity Box 68760. Physician/Medical as attending IF FEMALE: 23d. Date of delivery use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown P.O. the signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 of Vital Records, 2 ■ No 3 □ Probably 4 □ Unknown 1 ☐ Yes should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No The 2. No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 ER/Outpatient 3 DOA 1/5 Inpatient 1 Tes 2 No ၉ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? completely filled in by the funeral 27. Manner of Death Certification: i or Attending F s after death. I Director: After Injury Division 1 X Natural 5 Pending investigation 1 Tes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the l within 2 To the l 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 July 16, 2008 a spenglow, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Spengler, 600 North Wolfe St, Baltimore, MD, 21287 0-HC 32. F gistrar's Signature 31. Date filed (Mor State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea Month, 2008 **Physician** Walker 14/ Lee Ruby /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner P.G. Lanham Doctor's Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 □ 75 Yrs. Va. 7-28-32 Director 577-56-2849 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Widdel Event or other traumatic event, the Widdel Event or other traumatic event, the Widdel Event or other traumatic event, the Widgel Event or other traumatic event. 1 Yes 2 □ No Hyattsville P.G. Director MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20781 5808- 42nd Avenue, #211 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: Black Maryland 21215-0036 1 ☐ Yes 💥 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Housekeeper 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Fields Herman Walker ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cassandra B. Weakley/Niece 201 E. 10th St. Sheffield, Ala. 35660 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Md. 7/17/08 Fort Lincoln 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. 21. Signature of Funeral Service Licenses Nackon W. 814- Upshur Street, N.W. Approximate Interval Between Onset and Death art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Carcinomy Physician Heratoc /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a contequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending p for use as t IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) ed by the a 9 ☐ Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏌 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy director, page 2 s performe 2 No 1 ☐ Yes 2 □ No certificate 1 ∐ Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1∐ Yes Inpatient ၀ this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director, After Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12abeth Fasi Ka 8/18 Good Luck LOUB Lunh Um

State

Registrar

31. Date filed (Month, Day, Year)

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32 Begistrar's Signature

	1- For Amend #17 po	State of Maryland / Der FH G882 8/11/08	epartment of Health and I Certificate of Death	Mental Hygie _{Reg.}	n <u>2</u> 0 0 8 _{No.}	24582
Physician (Madisol	Decedent's Name (First, Middle, L Geneva	H.	Ware		Day Year _6 2008	3. Time of Death 2:30 PM
/Medical Examiner			4b. City, Town, or Location of Deat	h	4c. County of Death	2.30 111
	4910 78th. Ave		WestLanham Hil		Prince G	
Funeral Director	577-72-8919	Sex 7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Nov. 21,	1951 Wash	place (State or Foreign place) Lington, DC
ow stand	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location	· · · · · · · · · · · · · · · · · · ·		0d. Inside City Limits
e Many 3e-f sh fiffied	Maryland Prince (eorges West La	nham Hills			¥ Yes 2 No
uter death with the Mainter death with the Mainternas 23a or 28e-f significant percetified.	10e. Street and Number 4910 78th Ave.		10f. Zip Code 20784		Citizen of What Could	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural; or items 23a or 28e-f show any injury or other treumatic event, the Modical Examinations the multiple at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 Yes X No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	etc.
72 hours affined by Fated by F	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's 8	Year or Dates:	ecedent's Usual Occupation give kind of work done during most of work	16b	Specify: Bla b. Kind of Business/In	
ed within 72 horygiene. Ser then "netura". It, the Wolfall.	(Specify only highest gi	Callege (1-4or 5+)	āive kind of work done during most of wol fe. DO NOT use retired) ACher		S. School	
d be filed antal Hyg set other c event,	17. Father's Name (First, Middle, Las	t)	18. Mother's Nar	me (First, Middle, Maid		Dyscen.
should and Men armarke urmatic	19a. Informant's Name/Relationship	born Keffer Evans (Type, Print) 19b. N	Vera M. (Mailing Address (Street and Number or Ru		ity or Town, State, Zip	Code)
Tand 2 1 and 2 1 ealth a 1 ealth a 1 ealth a 1 ealth a	Leo F. Ware		10 78th Ave. West I			
Definition of Pages 1 Department of Pages 1 Mportent: if ite Ny injury or of	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State Chesapea		17,2008	Beltsvill	e, MD
Departiment important in portant	21. Signature of Furneral Service Lice	Bul	22. Name and Address of Facility Re 9013 Annapolis Rd.			ome
	23a. Pag. Enter the disea e, or co slock, or heart failure. List mediate Cause (Final	one cause on each line.		or respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death)	Pulmonary Hypert Due to (or as a consequence of)				6 yrs.
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ficate be executed ficate be executed physicien and its the burial-transit edical Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
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that the death certificate be executed on the attending physicien and detached for use as the burial-transity Physician/Medical Examily	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
igne d	Part II. Other significant conditions	contributing to death but not resulting in th	ne underlying cause given in Part I.		co use contribute to t	he cause of death?
The law requires the has been signage 2 should be ompleted by				24a. Was an		psy findings available
: The la cate has page 2				autopsy performed 1 ☐ Yes 2 🛂	prior to co death?	mpletion of cause of
certifica rector, p	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Other	ath (Check only one)		
To the Hospitel or Attending Physicien: The law within 24 hours after death, within 24 hours after death, or the Funerel Director: Attenthis certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Compl		28a. Date of Injury (Month, Day Year) 28b. Tim Inju	ne of 28c. Injury at Work?	lome 5X Residence 28d. Describe how in		(y)
or Attending Fafter death. Director: After I in by the funers	2 Accident investigation 3 Suicide 6 Could not determined	DB 290 Blace of laive. At home form	M 1 ☐ Yes 2 ☐ No , street, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
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fo the within 2 omple	29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month,	
(18)		ven-Cohen			ly 17, 200	08
20	Ruth Reven Cohe	n 8700 Georgia Ave	pe. Prid 00 Silver Spr	ing, MD 20	910	
State Registrar	31. Date filed (Month, Day, Year) JUL 1 7 2008	32. Registrar's Signature	•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Johnie Willis 23:05 P M July 14, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 13 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 246-16-7059 XXM 2 F South Carolina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at MD Prince George's Clinton 1 ☐ Yes 2XXNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11602 Mary Catherine Drive 20735 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. should be filed within 72 hours after and Mental Hygiene. XXYes 2 No1942 If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Photo Lab Technician Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h Unknown Ollie Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any Injury or other tra 11602 Mary Catherine Dr., Clinton, MD 20735 Gwendolyn Scott - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State Cheltenham Vet. Cem. 7/23/08 Cheltenham, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Bell & Johnson Funeral Home, P.A. 6503 Old Branch Ave., Temple Hills, MD 20748 nt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sk, or heart failure. List only one cause on each line. achie V Stules Piscan Imme * te Cause (Final Physician disease or condition resulting in death) /Medicai Examiner Sequentially late of Jenses if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine that the death certificate be executed and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical as 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Division or Vital Records, P.O. 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform 2 No I ☐Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred al or Attending I 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Pritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital within 24 hours at to the Funeral D State

(Check only one) 29b. Signature a

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Registrar

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cause of death (Item 23a) (Type, Print)

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	Dhysisi		1. Decedent's Name (First, Middle, Last)						ate of Death	Day '	Year	3. Time of Death
	Physici /Medic		Yoon Soon Yoon						11y 14	2008		9:30 P. M
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			304 Careybrook Lan 5. Social Security Number 6. Sex		rs. last birthday)	Oxon Hi	L1 If Under 24	Hrs. 8 r	ate of Birth	Prince		
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	th wit	aD	304 Careybrook Land	e		20745			K	Corea		
ယ္	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f show aumatic event, the Medical Evant at must be multified at	Funeral	1 Never Married 2 Married	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 No If Yes, Give	i	Was Decedent of H 1 Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin n, Mexican, I Specify:	n? (Specify Puerto Rica	Yes or No- n, etc.)	Black	- Americ , White,	an Indian, etc.
Maryland 21215-0036	urai',	d by	3 Widowed 4 □ Divorced	Year or Dates:						Specify:	Asi	
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0	filed Hygi other ent,	0	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	Trome .	lanci	18. Mother's	s Name (Fin		aiden Sumame		
<u>a</u>	should be and Mental s markad o	To B	Unknown				Unknov	√n				
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altimore,	parmit. Pagas 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 900.9.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3X R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval mom State	b. Place of Dispo cemetery, cren	sition (Name of matory or other place Mem. Par	^{э)} Jı	11y 17	, 2	oc. Location - C	City or To	own, State
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Division of Vital	<u> </u>	on: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	z) 28b. Time o	f 28c. Injur Wor	y at k?	28d.	Describe hor	w injury occurre	id	
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_	To the Hospital within 24 hours a To the Funeral I completely filled	O	29a. Certifier 1 X Certifying Phys	sician: To the best of my	knowledge, deat	h occurred at the tir	me, date and	place, and	due to the ca	use(s) and mar	ner as s	stated.
	n 24 the Ho	edical	(Check only 2 Medical Exami one)	ner: On the basis of exar and manner stated.	nination and/or in	vestigation, in my o	pinion, death	occurred a	t the time, da	te and place, a	nd due t	o the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier	Vale	1 0	29c. Licens	e number		29	ld. Date signed	(Month,	Day, Year)
	7			L solder	o Ulu	9 D3271	17			July 15	, 20	08
	9		30. Name and address of person who co						21001			
	<u> </u>		Fernando A. Delgad 31. Date filed (Month, Day, Year)	0, M.D., 75		Drive,	lowson	, MD 2	21204			
	Sta Regist		JUL 16 20		M. M.	marks.						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:43 P. M Joseph Armiger Ju₁y 24 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel 530 Alden Street Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F 93 212 09 9707 Maryland Director 05/15/1915 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🙀 No Director Anne Arundel Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 530 Alden Street 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MINo If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th Superintendent Construction Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph E. Armiger Augusta Bernschein ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Eula Armiger / Wife 530 Alden Street Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 07/28/2008 | Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature de run eral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PIA **Physician** BE 10/26/00 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PHOISHIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day signed by the a d be detached for 5 Other (specify) TYes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig , page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Hospital or Attending P 4 hours after death.
Funeral Director: After t ely filled in by the funera After t 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOVEN ST BALTIMONE MD Day, Year) 2. Registrar's Signature 31. Date filed (Ma State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 25% 9-00 AM **Physician** JUM 2008 Mary Anderson /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** en Knrn FRW. Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Year) Months Days Hours 1 □ M 2 🖾 F 80 04/13/1928 Maryland 220 20 2311 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan natural by routiled at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 1 ☐ Yes 2 🛣 No Director Glen Burnie Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21060 7355 Furnace Branch Road East Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Weldon Gill Agnes Isabel Hilton ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7355 Furnace Br. Rd. E. Glen Burnie, Maryland 21060 Joyce Allman / SSD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/01/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Sun 1 Service Lic Igno 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that in list and accepts. Due to (or as a consequence of) Examine that initiated events resulting in death) Last and I-trar Due to (or as a consequence of) attending physician a for use as the burial certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death The law requires that the death in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a d be detached f Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 No 2 No 1 ☐ Yes of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) t inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Division or Attending Natural 5 Pending investigation after death.

I Director: Af din by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 🗌 Homicide within 24 hours a Hospital TSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 15017 0

DHMH 17 Rev 1/2001

State Registra

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32 Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

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Division To the Hospital or Attend within 24 hours after death. To the Funeral Director:	ly filled		4 Homicid 29a. Certifier (Check only 1	le	etermin Physi		ecify) ne best o	of my know	ledge, deat	h oc	ccurred at	the time,	, date and	place, a	and due to the	ne cause	e(s) and ma	nner as	stated.	e(s)
To the I	mplet	Medical		✓ Medical E	xamin	er:On the I	pasis of nner stat	examinatio	n and/or in	vest	igation, in	my opin	ense numb	occarro		5, 0210 0			(Month, Da	y, Year)
	N°	ž	29b. Signature	and title of cer	tifier		ml						C.M.E.				July 25	2008	3	
1000		}	30. Name and a			o complete	d cause	of death (I	tem 23a)	4	11 Don	n Stro	et Baltin	more	MD 2120	 01				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2008 July 24, 8:00a^M Frances Elizabeth Angel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 245 South Regester Street N/A Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2X F 2-28-1945 214-44-5851 63 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 X Yes 2 □ No Directo MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 21231 245 S. Regester St. USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) N/A 10 <u>Bar Maid</u> Hospitality 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Walter A. Miller Mary Lehmann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7904 Redmore Road Baltimore, MD 21237 Marian Pizzini - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 7-28-08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic 2Hrow 81 Physician colon concer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed physician and is the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending plant as IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 I Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 **E/*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the I within 24 80

Ann Zimrin, M.D. 22 S. Greene Street Baltimore, MD 21201

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State Registrar

(Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

25/08

08-05725	
Edna Bedford	

-05725		Please Type or Print in Black Indelible Ink. Ensure All C			ole.	200	2458
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Sion Attendi r death. ector:	icatio	1 V Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, e		Location (St	reet and Numb	er or Rural F	Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plone) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc	lace, and due	to the cause time, date ar	(s) and manner nd place, and c	r as stated. due to the ca	use(s)
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5		Joinh Jegnis O.C.M.E.	·····		July 26, 20	108	
6		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21	201			
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			For State Registrar	State of Marylan		rtment of F ctificate of			giene Reg. No.	2008	24590
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	a or 2	D.	10e. Street and Number	200	1	10f. Zip Code	111		10g. Citiz	en of What Co	untry?
	ns 23	Funeral		mes Roac 12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	<u> </u>	4. Race - Ame	rican Indian.
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or Items 23a or 28a-f show event, I'm Medical Exercit att. ust be rectified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify Cub I □Yes 2☑No	an, Mexican, Puerto Specify:	Ricán, etc.)		Black, White	
5-0	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occup	during most of work	ing	16b. Kin	d of Business/	Industry
121	within ene.	dui	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT use retired	d)		7~	L aClies	م مراد الماد
	filed Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)	<u></u>		Care	18. Mother's Nam	e (First, Middle,	_	t.ct (Carname)	SHO - HUNGI
ılan	should be filed nd Mental Hygi marked other imatic event, II	To B	Leslie Mar-	Lin			Edna	M.S	Smi	th	
Maryland	S S S		19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	g Address (Street	and Number or Ru	rai Route Numb	er, City or	Town, State, 2	Zip Code)
	5 7 N F		Leslie 7. Cook	/ Daughter	2012	Lakei	wood S	+, Su	itla	nd, M	020746
זסר	S = = 0		20a. Method of Disposition 1 Burial 2 Cremation 3 F	Removal from State	emetery, cren	sition (Name of natory or other place	ce)	Date	20c. Loc	ation - City or	Town, State
Baltimore,			4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	<u> </u>		Name and Addre	ST: 8-9	11/6/20	OW	ireene	LILIS, MUD
Ba	permit. Departr Importa any Inju		Mayon C.		8	728 Li	berty s	22 20	_	listour	1 MJ 21133
			23a. Part 1. Enter the disease, or compl shock, or heat trailure. List only or	cations that caused the death	n. Do not ent		ng, such as cardiac	or respiratory a	-	1010-1	Approximate Interval Between
and a	Physician		Immediate Cause (Final disease or condition	Areur							Onset and Death
· A	/Medical Examiner		resulting in death)	Due to (or as a consequence							days
п	Exammer	J.	Sequentially list conditions,	Renal Renal		re - Ch	ronic				years
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence or):						140
Ć,	exection and ital-tra	Exal	that initiated events 'resulting in death) Last	Due to (or as a consequ	uence of):						years.
68760,	ificate be executed g physician and is the burial-transit	edical		Sepsis							days
		Med	IF FEMALE:							1	1-
O. Box	law requires that the death cert as been signed by the attending 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ◯ ◯ (10)	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous 9 ☐ Unknown	Ideath 3	Ectopic pregnand Other (specify) _	у		2	3d. Date of del Month	ivery Day Year
σ.	that the dened by the detached		9 ☐ Unknown Part II. Other significant conditions con	ntributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I	23e Did t	ohacco us	se contribute to	the cause of death?
of Vital Records,	w requires that s been signed t should be deta	d by	3			.co.ryg cadoo gre	on in run.		Yes 2□		
COI	s beer	Completed						24a. Was	an	24b. Were au	itopsy findings available
Re	The lar	ошь						autor perfo	rmed?	prior to death?	completion of cause of
ital	ysician: The lav is certificate has director, page 2	Be C	25. Was case referred to medical examiner?				26. Place of Dear	1 ☐ Yes th (Check only o	2 No	1 ☐ Yes	2 (No
of V	S	ပ္	1 Yes 2-ANO	lospital: 1 Inpatient 2			4 LI Nursing H	ome 5 Resi	dence 6	□ Other (Spe	cify)
	ding h. After fune	tion:	27. Manner of Death 1 Natural 5 □ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	ryat k? Yes 2 □ No	28d. Describe I	now injury	occurred	
Division	l or Attending after death. Director: After in by the funer	fical	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	ome, farm, stre		ites Z LINO	28f. Location (Street and	i Number or Ru	ural Route Number,
Ö	i Site	Certification:	4 Homicide determined	building, etc. (Specif	y)			City or To'v	vn, State)		,
	To the Hospitai or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) CHECK ONLY C	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deatl tion and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
_	Vith Com	Σ	29b. Signature and title of certifier			29c. Licens				signed (Monti	
	\triangleleft		WAX	2 mp			56632		Ju	14 29	7 2008
1	5			ompleted cause of death (Item	23a) (Type,	Print)	A 1	9 1			2008
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa		LOUVY 1	kd K	andalls	900m	by, Me	2 ×118
	Registr		JUL 3 1 20	08 Sincere s	1. An	anti-					
DH	MH 17 Rev 1/2	001		-	3						

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 8, per fh, 2889, 03/24/09dhb

Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 07 Day **Physician** 26 Henrietta Helen Borkowski 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 05/21/1922 1 □ M 2 🕱 F 86 Maryland 214 16 8727 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Pasadena Director Anne Arundel Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. 21122 8568 Main Avenue Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley Siemienski Stella Wierczeszka 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pasadena, Maryland 21122 Patty Wrobel / Daughter 8568 Main Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland 07/30/2008 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 22. Name and Address of Facility 21. Signature of Pune al Service License Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused de death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ti brillation Physician Atrial NEEK disease of condition /Medical Due to (or as a consequence of): Examiner Stenos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Jue to for as a sunsequence of Physiclan: The law requires that the death certificate be executed the attending physician and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☑ No 1 ☐Live birth 3 Ectopic pregnancy for Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has director, page 2: autopsy performed 1 ☐ Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hours after deat ineral Director; 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours a Hospital Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Bolad M.D. aleed

State Registrar University

32. Registrar's Signature

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Union

31. Date filed (Month, Day, Year)

AT2438946

BOLAD

Baltimore,

MO 21218

Park way

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2008 FRANK JULY 28 11:15P BLUM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/26/1921 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 87 Yrs. 216-12-0708 Director Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 SLADE AVENUE, #212 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No WWII If Yes, Give Year or Dates: ARMY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE ģ Specify: 3 ₩ Widowed 4 Divorced "naturai", Completed injury or other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) should be filed withi and Mental Hygiene. OWNER FURNITURE STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DAVID BLUM SYLVIÄ FRIEDMAN ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trace ALAN BLUM / SON 2106 SUGARCONE ROAD, BALTIMORE, MD 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State lace of Disposition (Confer place of Disposition (Confer place AUATH YESHURUN SODOVA 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/30/2008 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final year **Physician** ronic disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe this certificate 2 🗖 No 1 ☐ Yes 2 No 1 □ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specif 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To To the Hospital or Attending Phemin 24 hours after death.
To the Funeral Director: After After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 29,2008 52307

State Registrar

2002

Blum

Frank

N. Charles St. Bulto Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GBMC

6701

32. Registrar's Signature

Riley

3

1 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** OUNT 0 28 200 /Medical or Location of Death 4c. County of Death Facility Name (If not institution, give street and Examiner N/A Birthplace (State or Foreign Country) If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) 6 Sex **Funeral** Months Davs Hours Min. **™** M 2□ F Director 7-31-1937 NEW JERSEY 70 155-26-7681 Usual Residence of Decedent 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 X Yes 2 No Director N/A BALTIMORE MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21217 USA by Funeral 1820 MOUNT ST. 14. Race - American Indian, Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2♥ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Tyes 2 No Maryland 21215-0036 Specify. Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LABORER PAPER COMPANY 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be JAMES STEVENS ALVERTA BROWN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3705 ERDMAN AVE. BALTIMORE, MARYLAND 21213 SHARON OLIVER (SISTER) Department of Health Important: If item 27 any injury or other to once. Saltimore. 20a. Method of Disposition

1 Burial 2 Dicremation 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 3 Removal from State 5 Other (Specify) WOODLAWN CEMETERY 8-2-2008 BALTIMORE, MARYLAND 4 □ Donation HIBNER2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of Fund Service 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part / Enter the disease, or complications that caused the death. show, or heart failure. List only one a use on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 2 daxs (or as a consequence of) /Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, physician Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 5 Other (specify) signed by the a 1 □Yes 2 □No Ö 9 Unknown ۵. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed 1 □ Yes 2-1 No 1 ☐ Yes of Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 LNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Lapatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred spital or Attending P nours after death. neral Director: After i / filled in by the funera Division 5 Pending investigation 1 L tural 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital c thin 24 hours af the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 흔 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh 881 7-31-08 vt State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 8 Reg. No.2 1 18 1. Decedent's Name (First, Middle, Last) Virginia Marie Cochran 2. Date of Death **Physician** 13:20 M 25 2008 07 Maris Cochran Virginia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil Elkton Union Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ F Yrs. Director 50 216-54-3066 08 02 MD Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No by Funeral Director Elkton Cecil MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21921 U.S.A. 4 Montgomery Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) F.E.M.A. Disaster Project Manager 12th Grade 4yrs 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Beverly P William Morrison 19b. Mailing Address (Firest and Number or Rural Route Number, City or Town, State, Zip Code) 21215
4008 Fodleight Road, Apt B, Baltimore, Md and 19a. Informant's Name/Relationship (Type. Print) Kimros Buchanan-Daughter Health tem 27 i permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 7/31/08 Woodlawn, Md 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Licensee 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter tile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SUB ARALLNOOD Hoemonhere disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HEPATITIS C LIVER if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed Acuti Ruch physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical Bleede attending pl for use as t IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 XNo 4□Pregnant at time of death 5 Other (specify) n signed by the a Id be detached f P.O. 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ SEIZURE DISORDER 2 **y** o 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DIABETES MECLITUS 24a. Was an has autopsy page perforn certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this funeral dir Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) B.V-Noyen D DOO 65733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V-PULA NARATANA RAO NORTH JTREET. SUITE 3B ELKINN MD 21921 118 32. Pagistrar's Signature Year) 31. Date filed (Month, State 1 ORUGES Registrar

Division of Vital Records, P.O. Box 68760, 2

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		1	For State Registrar		State	ועו וכ	ai yiai iu	•	rtificate			ario ivi	entai i iy	Reg. No		38	24595
Phys		n	1. Decedent's Name Edward										2. Date of De Month 7-27-	Da	y Y	ear	3. Time of Death
	edic: mine		4a. Facility Name (h			um <i>ber)</i>			4b. City, Tov		Location o	f Death			. County of	Death Bal	to
Fune	ral		5. Social Security N			"	e (In yrs. las		If Under 1 Y		If Under 2	24 Hrs.	8. Date of Bi (Month, D 2-14	rth ay, Year)		. Birthp	lace (State or Foreign
Direct	tor		216-20-10 Usual Residence of		1√ M 2□ F	82	2	Yrs.					2-14	-192	.6		Md.
// show	10		10a. State Md.	10b. County	lto.		10c. City, "	Town or Lo		.	. h. a					11	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
ith the / or 28a-		Funeral Director	10e. Street and Nun		110.		<u> </u>		Nott:	ode				10g. Cit	izen of Wh	at Coun	
eath w	INE	era	9114 Ki	1bride		odont l	Ever in I.I.C.	112.1		212		ing (Cne	oifu Voo os N		USA	Amorio	on Indian
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. Item 2010 is a small or continued to continue the notified at		2	11. Marital Status 1 Never Marrie 3 Widowed		ied 12. Was Dec Armed F 12. Yes If Yes, G Year or	orces? 2 🔲 N live			Was Decedent If Yes, specify I □ Yes 2		Specify:	gin? (Spe , Puerto i	Rican, etc.)	0-	14. Race - Black, Specify:	White, e	tc.
115-(in 72 h in "natu	Name of the last	Completed			st grade completed			(Give	dent's Usual C kind of work o DO NOT use r	lone d	durina most	of workii	ng	16b. K	ind of Busi	ness/Ind	lustry
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and d be file ental H ced oth		m	17. Father's Name (First, Middle, .d Corr	•								(First, Middle .na Sie		Surname)		
Maryland Id 2 should be file lith and Mental Hy 27 Is marked oth		٥ .	19a. Informant's Na					19b. Mailir	ng Address (S	treet a					or Town, St	ate, Zip	Code)
re, M 1 and 2 Health tem 27 I		-	Maria Mez 20a. Method of Disp		Sist	er	20h Plar		114 Ki				Nottin	-	Md.		
Baltimore, permit. Pages 1 ar Department of Hee Important: If Item			'	Cremation	3 ☐ Removal from pecify)	State		etery, crer • Car	sition <i>(Name o</i> natory or other me1	r place	e) ¦	_	-2008		alto.	-	
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2 any inlury or other	once.		21. Signature of Fu	neral Service	Licensee			ĺ	. Name and A			Sc	himune				ne
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f Vill nystora nis cert directe		o Re	examiner?		Hospital:	Inpatie	nt 2 ☐ EF	l/Outpatier	t 3 DOA	Othe			<i>(Check only</i> ne 5 ☐ Res	-	6 □Other	(Specify	·)
Vision of Vita Attending Physiolan: r death. ector: After this certific by the funeral director, i			27. Manner of Death	5 ☐ Pending investig		of Injui	ry 28 v, Year)	Bb. Time of Injury		Injury Work	/ at	2	8d. Describe				
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determi	not be 28e. Plac	e of Inju ling, etc	ury - At home c. (Specify)	e, farm, str	eet, factory, off		res Z		8f. Location (City or To			or Rura	l Route Number,
the Hospital or hin 24 hours afte the Funeral Dir			29a. Certifier (Check only one)	1. Certifyin 2 Medical I	g Physician: To the Examiner: On the and ma	basis of	f examination	edge, death n and/or in	n occurred at t vestigation, in	he tim	ne, date an pinion, deat	d place, a	and due to the	e cause(s , date and	and mani d place, and	ner as s d due to	tated. the cause(s)
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J	_		Rame and addre	Saba	palhi		120	Bac	Print) Kriver					sex,	MD	212	21
Regi	State istra		31. Date filed (Mont)		2008	Tegistra	ar's Signature	dos.	المريك المريك								

			For State Registrar		State of N	/larylan		artment of H r <i>tificate of L</i>		and Me		jienę leg. No.		2459	16
		i	Decedent's Name	(First, Middle, Las	it)						2. Date of Dea	th		3. Time of Dea	th
	Physicia Medic		IRMA					CARRO)LL		JULY	26		1:15 A	М
	Examin	er	4a. Facility Name (If			1	מקוש	4b. City, Town, or				4c.	County of Death		
	Funeral	ý	5. Social Security Nu	umber 6. Se		Age (In yrs. I		If Under 1 Year	REST I	24 Hrs. 8	8. Date of Birth)	HARF(place (State or For intry)	reign
ы	Director		215-09-5	202	□M 27 F	89	Yrs.	Months Days	Hours	Min.	(Month, Day 08-09-1	918	Unkr		
	land bw		Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	cation						10d. Inside City Lir	mits
	a-f sh	ctor	MD	Harfo	ord		Fore	st Hill						1 □Yes 2√X]No
	or 28	Dire	10e. Street and Num		- Di			10f. Zip Code	٥٥٥			-	zen of What Cou	intry?	
	eath v rs 23a must	Funeral Director	109 FOTE	st Valley	12. Was Deceder	t Ever in U.	S 13 1		050	nin? (Spec	ify Yes or No-	USA	14. Race - Amer	can Indian.	
21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Int or other traumatic event, the Medical Examiner must be notified at Iry or other traumatic.	þ	1 Never Marrie		Armed Forces 1 ☐ Yes 2 If Yes, Give Year or Dates	s?] No		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2⁄ No	in, Mexicar Specify:	n, Puèrto R	ican, etc.)		Black, White		
5-0	"natu	letec	(Speci	15. Decedent's Ed ify only highest gra	ucation de completed)		16a. Dece	dent's Usual Occupa kind of work done o DO NOT use retired	ation during mos	t of working	9	16b. Ki	nd of Business/li	ndustry	
121	within iene. than the Me	Completed	Elementary/Secon	ndary (0-12)	College (1-4o	r 5+)		maker	"			70	wn Home		
b	e filed al Hyg other	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (First, Middle,				
yla	iould b	To I	Unknown				T		Unkr		_				
Maryland	nd 2 sh th and 27 is n traum		19a. Informant's Na	eidman (A				ng Address <i>(Street a</i> Washing t o						,	
ore,	of Hea	1	20a. Method of Disp	osition			lace of Dispo	sition (Name of matory or other place	i	Da			cation - City or 1		
Baltimore,	Page ment c				Removal from Stat	e		Crematory	i	08-29	-2008	Bal	timore,	MD	
Ball	permit. Pages Department of Important: If II any Injury or once.		> sly	neral Service Licen)		I.	2. Name and Addres	. Mac	Phail	L Rd Be	1 A:		ne of Bel 21014	Air
P			23a. Part1. Enter the shock, or hear		olications that cause one cause on each	ed the death line.	. Do not ent	er the mode of dyin	g, such as	cardiac or	respiratory arr	rest,		Approximate Interval Betweer Onset and Death	n h
	Physician /Medical		Immediate Cause (F disease or condition resulting in death)	rinal 1	a. Due to (or a	134		demente	L						
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Vita	iclan: Th certificate ector, pag	Be	25. Was case referr examiner?		Hospital:			t all DOA Othe			(Check only or				
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ion	ath. or: Afte	atior	↑ Natural 2 Accident	5 ☐ Pending investigation		ay Year)	Injury		k? Yes 2∐l	No					
Divis	al or Atte s after de al Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	20e. Place of I	njury - At ho etc. (Specify	me, farm, str	eet, factory, office		28	Bf. Location (S City or Tow	treet and n, State	d Number or Ru)	ral Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis and manner:	of examinat	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date ar pinion, dea	nd place, as ath occurre	nd due to the o	ause(s)	and manner as I place, and due	stated. to the cause(s)	
_	To t To tl	ž	29b. Signature and					29c. License					e signed (Month		
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	2		DAVID DU		5 W. MAC	PHAIL	ROAD	- BEL A	IR, M	ID. 2	21014				
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	/M
-	Exa
Il Records, P.O. Box 68760,	The law requires that the death certificate be executed
Division of Vital	To the Hospital or Attending Physician:

		1 - For State Amend #5, pe	State of M rFh G882 8	laryland .6.08	/ Depa ^{TT} Cer	rtment of H tificate of E	ealth and I Death		giene 20 Reg. No.	08	24597
Physicia	an	1. Decedent's Name (First, Middle, L	,			-		2. Date of Dea Month	th Day	Year	3. Time of Death
/Medic	al	4a. Facility Name (If not institution, g	Vernon I		s Clar	k 4b. City, Town, or	Location of Death	July	26 200 4c. County		7:00 P. ^M
Examin		1628 Cherry St		/		**	timore		N/A		
Funeral Director		214 74 7437	Sex 7.A 1▲ M 2□ F	ge (In yrs. las 51	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 27,	y, Year)_	COL	place (State or Foreign intry) 'yland
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
a-f sh	ctor	Maryland N/A		Ва	altimo	re					1 X Yes 2☐No
vith the	Director	10e. Street and Number				10f. Zip Code	004		10g. Citizen of		intry?
ns 23	Funeral	1628 Cherry St	12. Was Deceden	t Ever in U.S.	13. V	Vas Decedent of His	226 spanic Origin? (Si	pecify Yes or No-	U.S.		ican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar roust be neithed at once.	þ	1 ☐ Never Married 2 █ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 MYes 2 If Yes, Give Year or Dates] No	11	Yes, specify Cubar ☐Yes 2 X No	Specify:	o Rican, etc.)		ck, White, ^{y:} Wh	etc. nite
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nd 2 sl alth an 27 is r r traur		19a. Informant's Name/Relationship Sharon Cermak /				g Address (Street a Cherry St		rai Houte Numbe Baltimor			•
of Hez of Hez fitem		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3	□ Domovel from Ctot	20b. Pla		sition (Name of natory or other place		Date	20c. Location		
t. Pag rtment rtant: I		4 ☐ Donation 5 ☐ Other (Spec	oify)			rematory					Maryland
permi Depar Impor any Ir		21. Signature of Fune al Service Lic	Mar	dose	4 (ie Highw		timore,	rvice Mary	land 21225
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Physician /Medical		disease or condition resulting in death)	a. Due to (or a	s a conseque		CELL	24/	19401	7.7		
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cate be chysici the bu	dical	•	d								
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lcian: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Otho		ath (Check only)	•		
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Veith Veith Com	Σ	29b. Signature and title of certifier	- M.	7		29c. License			29d. Date sign		
, , \		30. Name and address of person wh	o completed cause of	death (Item	23a) (Tvne	Print)	266		0'/		12008
U'		Fer Even 1	10 572	2//	Dole	e Stre	et Bo	14,000	~ /	10/	9/2008 had 2124
Sta Registr		31. Date filed (Month, Day, Year) JUL 3 1 200	32. Regis	strar's Signatu	ire	8)					

		For	State of Marylan	d / Depa	artment of H	lealth ar	nd Mental Hy	giene		
		1 - State Registrar		Cei	rtificate of	Death		Reg. No. 2	008	24598
		1. Decedent's Name (First, Middle, La	_ /	,			2. Date of De	eath Day	Vone	3. Time of Death
Phys /Me	ıcıan dical	EVOL Mar	rie Clou	194	1		Ju1y		2008	9:30 A. M
	niner	4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of	Death		nty of Death	
A Section	-0	7972 Nolpark C				Glen E			e ARur	
Funer Direct		5. Social Security Number 6. S	ex 7. Age (<i>In yrs. I</i> ☐ M 2 🗗 F 64	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bit (Month, Date of Bit 1)	ay, Year)	Coun	lace (State or Foreign try) vland
pu ,		Usual Residence of Decedent	100 0:4	, Town or Lo						011
Maryla I-f shov fled at	tor	Maryland Anne		Glen B						0d. Inside City Limits 1 ☐ Yes 2 🛣 No
h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Coun	try?
th will		7972 Nolpark C	ourt Apt. 202		2	21061		U.	S.A.	
r dea ems	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origi an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.))- 14. R	lace - America Black, White,	
be filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. do ther than "natural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛂 No	Specify:		Spec	cify: Wh	ite
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uld b Wenta	2		Albert Bussey				Fannie Red	din		
is 1 and 2 should life Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship					or Rural Route Numb			,
and and ealth		Sharon Brigugli					Road Ridg			
Pages 1 nent of H int: If iter		20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 D	Removal from State	lace of Dispo emetery, cre	osition (Name of matory or other pla	1	Date		n - City or To	
t. Partmen		4 □ Donation 5 □ Other (Speci			Crematory		7/29/2008			Maryland
permit. Pages Department of Important: If it any Injury or or	ouce	21. Signature of Fineral Service Lies	landge		2. Name and Addre		Gonce Fur ghway Bal			
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not en	ter the mode of dyi	ng, such as c	ardiac or respiratory a	arrest,		Approximate Interval Between
Physicia /Medic		Immediate Cause (Final disease or condition resulting in death)	a. Emp		ema					Onset and Death 5 years
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attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3[☐Ectopic pregnanc☐Other (specify) _	y			Date of delive Month	ery Day Year
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ires that signed by		Part II. Other significant conditions	contributing to death but not resu	ulting in the u	inderlying cause giv	ven in Part I.	23e. Did	tobacco use co	ontribute to th	ne cause of death?
The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	ed by						1_	Yes 2□ No	o 3 ☐ Prob	ably 4 Onknown
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	E O						perf 1 Yes	ormed?	death?	2 No
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Attended death death ctor:	ficat	3 Suicide 6 Could not b	e 28e Place of injuny - At he	ome, farm, st		103 2 10		(Street and Nu	mber or Rura	il Route Number,
al or safter	Certification	4 Homicide determined	building, etc. (Specify	y) .			City or To	iwn, State)		
To the Hospital or Attending Physician: within 24 hours after death to the Funeral Director. After this certific completely filled in by the funeral director,	Medical (29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, dea tion and/or in	th occurred at the three	ime, date and opinion, deat	d place, and due to the h occurred at the time	e cause(s) and , date and place	manner as s ce, and due to	tated. the cause(s)
To the within To the Youth	Z	29b. Signature and title of certifier	٨.		29c. Licens	se number		29d. Date sig	ned (Month,	
		1	d		100	066	19	Jule	128	12008
to		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print) 4710	pen	neusta	s Au	· Ba	Stime.

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24599 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30°, Physician 20්රී්8් July 12:08 PM Cynthia Derring /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8034 Maywood Avenue Pasadena Anne Arundel 8. Date of Birth (Month, Day, Yea May 4, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕅 F 218-82-9209 48 1960 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 💢 No Director Maryland Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21076 893 Forest Lane USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bar Bartender 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patricia Buckingham Phillip A. Derring ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kate Baer, Sister 8034 Maywood Avenue Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 07/31/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. ^{22. Name and Address of Facility}
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service (degree Thomas Gregor Frederick Road Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final WELLIAM **Physician** Notes to the disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. Box 68760,CL that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by rs 5 KM O 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? $-\mathbf{Y}$ autopsy performe 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Sister's Residence Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled

State Registrar

Medical

29a Certifier

(Check only one)

29b. Signature and title of certifier

YNOZ 1406 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated.

Mb

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

063726

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n so V

BIRTESS MD 51001

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #30 per DVR g881 //31/08 TT
State of Maryland / Department of Health and Mental Hygiene
1- State Amend #10a&10e,per Inf/Fh G882 8/1/08 TT
Reg. No. 2 | | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Edmund Crain Davis July 29, 2008 /Medical 8:55 A. 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** 1 X M 2 □ F Vrs 213-07-6985 Director 97 July 8, 1911 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at MD 1 ☐Yes 2 No Director Maryalnd Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code S334 719 Maiden Choice Lane BR240 21228 USA Funeral ral", or items ! Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 "natural", or Specify: White 1 ☐ Yes 2 🖾 No Specify. δ 3 Nidowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H ttem 27 is marked ott Be Newlin Fell Davis 2 Ethel Reeder Crain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12009 Greenwick
Creenwood Dr. Oklahoma City, Oklahoma permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Edmund Crain Davis, Jr. Son 12009 73162 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/2/2008 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death astale Immediate Cause (Final disease or condition resulting in death) Cauce **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualty for nero consequence offi certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 Ma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Jas page 2 s autopsy performed? certificate 1∐ Yes 2 No Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation Injury 1 ETNatural n 24 hours after death.

Per Funeral Director: A pletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year). 145 im 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James R. Evans, MD 32 Registrar's Signature 31. Date filed (Month State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 7:00 P M 28 2008 KENNETH EARL DIEHL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1⊠ M 2□ F Director 218-18-9353 Apr. 26, 1924 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Evantiner must be notified at 1 ☐Yes 2 X No Director Maryland Harford Baldwin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2706 Park Heights Drive 21013 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2∑ No Specify δ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (1 and 2 should be 1 Health and Mental ဂ္ဂ Russell Earl Diehl Mildred (nmn) Powers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathy E. Hunt / Daughter 1304 Ipswich Drive, Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition of Baltimor Important: If it any injury or c once. 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □Other (Specify) Fairview U.M. Cem. 8-2-08 Phoenix, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Staphlococurs Sweeks Persisterst disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner etral aldo Se uentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury more burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last be Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month signed by the a 1 □Yes 2 □No Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: page certificate 1 ☐ Yes 2 ☐ No 1 □ Yes Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ð 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ision or Attending 5 Pending investigation death. 1 ☐Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month. Day. Year)

enneth

State Registrar 101

rea 31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

00000 **ORIGINAL**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO MASON

2. Registrar's Signature

es apaa

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State	State	of Marylan	_	artment of H		Mental Hy	/gien	е	
		Registrar 1. Decedent's Name (First, Middle	l netl		Cer	tificate of D	<i>Jeath</i>	2. Date of D	Reg. No	<u>°2008</u>	2460
Physicia		Joseph	, Lasy		8	ingers		Month	Di 24		11:20 PM
/Medic Examin		4a. Facility Name (If not institution	, give street and nu	m <i>b</i> er)		4b. City, Town, or	Location of Deat		40	. County of Death	
		The Johns Hopkins	Hospital			Baltimore	City				
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth av, Year)	9. Birth	place (State or Foreign
Director		219-16-3543	1 → M 2 □ F	83	Yrs.	Monaro Bayo	Tiodio IVIIII			1925 Mary	* *
pur »		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	cation					10d. Inside City Limits
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or ite	Ē	1 ☐ Never Married 2√ Marri	Armed F ied 1√2 Yes	2 🗌 No		f Yes, specify Cubar		rto Rican, etc.)	Į	Black, White,	
be filed within 72 hours after deat ital Hygiene. d other then "natural", or items : event, the Medical Examiner mu	þ	3 Widowed 4 Divorced	If Nes, G Year or [Dates: WW I		1 ☐ Yes 2 ☐ No	Specify:			Specify: Wh:	ite
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led w lygier her th		17. Father's Name (First, Middle,	4		OILIC	e Manager		ame (First, Middl			iipaiiy
be fi	Be		Lasty					attle (1 1131, Wildul	e, maios	iii duillaille)	
J Mer J Mer Jarke	၉	George 19a. Informant's Name/Relations	Engers		10b Mailir	ng Address (Street a	Anne	Kruse	hor City	ar Town State 7in	Codel
and 2 should ealth and Men n 27 is marke ier traumatic					1813					, Marylan	
1 and Healt em 2 ther		Elaine K. Enger	S/WILE	20b. I		Woodruff sition (Name of	Aveilu	Date	,	ocation - City or To	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", any injury or other traumatic event, the Medical Exa once.		1 Burial 2 Cremation		State	cemetery, crer	natory or other place				•	
artme artme ortani Injury		4 ☐ Donation 5 ☐ Other (S	icensee	ment Oak	Lawn 22	Cemetery Name and Addres	7/28	5/08	Bal	timore, N	Maryland
permit. Departr Importa any inju		1 21 11			97	05 Belair	a bood. Sood •	enimunek Saltimor	run M	erar nome arvland 1	21236
		23a. Part 1. Enter the disease, or									Approximate Interval Between
Physician		shock, or heart failure. List of Immediate Cause (Final	0	Λ.		4-				1	Onset and Death
/Medical		disease or condition resulting in death)		o (or as a conseq		<u>،</u>					
Examiner					,	BLASTIC	LEWIC	sm.A			
1000	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a conseq		-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	projection				
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		IF FEMALE:	00-16								
leath certifi attending (ian	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna birth 2 Teta	al death 3 🗆	Ectopic pregnancy			- 1	23d. Date of deliv Month	ery Day Year
the all	Physician/M	1 Yes 2 No	9 Unk	gnant at time of d nown	leath 5	Other (specify)			.		
w requires that the de been signed by the s should be detached	P P	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	inderlying cause giv	ren in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
signe d be	d by	AORTIC S	TENOSI	S				1 🗆	Yes	2 No 3 □ Prot	bably 4 🗌 Unknown
requestion shoul	lete							24a. Was	an	24b. Were auto	opsy findings available
has t	Completed							auto	opsy ormed?	prior to co death?	impletion of cause of
sician: The la certificate ha lirector, page		25. Was case referred to medical					26 Place of Do	1 ☐ Yes eath (Check only	2 <u>X</u> N	lo 1 🗆 Yes	2 No
ysiclan: s certific director,	Be Be	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Othe	15.	`		6 ☐ Other (Specif	(v)
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Atte	tific	3 ☐ Suicide 6 ☐ Could of determ	ined 200. Flac	e of injury - At ho		eet, factory, office		28f. Location City or To		and Number or Run	al Route Number,
salor salte ai Dir ed in	Certification:							1	,		
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical		Examiner: On the			n occurred at the tim vestigation, in my op					
o the	Me	29b. Signature and title of certifie				29c. License	number		29d. Da	ate signed (Month,	Day, Year)
		> From Hav	are, M	D		RES	-000		Ju	LY 25,	2008
15	ŀ	30. Name and address of person	71.5		m 23a) (Type,	Print)					
10		Fronce Havers					600	North W	olfe S	St, Baltimo	re, MD, 2128
Sta	_	31. Date filed (Month, Day, Year)	008	Registrar's Signa	ture						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Maryland / Department of Health and M Certificate of Death	lental Hygiene	008 24603
Physici /Medi		1. Decedent's Name (First, Middle, Las	L EVERETT	2. Date of Death	Year 7:30AM
Examir		4a. Facility Name (If not institution, give	Health+ Kehab Ellicoff City	+	ounty of Death toward
Funeral Director			7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hgs. Yrs. Months Days Hours Min.	8. Date of Birth Month, Day, Year)	9. Birthplace (State or Foreign Country)
ith the Maryland or 286-1 show	tor	10a. State 10b. County Howa	Columbia		10d. Inside City Limits 1 ⊟Yes 2 7 No
th with the 23a or 28e	Funeral Director	10e. Street and Number 5487 Halflight	t Garth 21045	10g. Citize	on of What Country?
ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland to 10 Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23a or 28e-f show or other treumstic event, the Medical Examinar must be rediffed an	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼No If Yes, Give 13. Was Decedent of Hispanic Origin? (Spr If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ▼No Specify:		Black, White, etc.
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of Health of Health if item 27 is		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □	comptent cramatons another place)	Date 20c. Loca	ation - City or Town, State
parmit. Pages 1 a Department of Hec Importent: If item any injury or othe		*4 □ Donation 5 □ Other (Specify 21. Signature of Funaral Service Licen	Naryland National 8.0	ne Funera	ure MU 6 Services
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es that the death cer igned by the attendin be detached for use	Physician/Medical	in the past 12 morths? 1 □ Yes 2 □ No 9 □ Unknown	1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		Month Day Year
w requires that been signed should be de	5	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?
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ding Phys	 	1 Yes 2 16	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Ho	me 5 Residence 6 (28d. Describe how injury	
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pitel or ours afte erel Dire	Cert	4 Hollicide	building, etc. (Specify)	City or Town, State)	
To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examone)	ysician: To the best of my knowledge, death occurred at the time, date and place, inner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	ed at the time, date and p	lace, and due to the cause(s)
or Name	-	29b. Signature and title of certifier	29c. License number 25398	7 July	signed (Month, Day, Year) 29 2008 20 212010
5		300 ARM OF	completed cause of death (Item 23a) (Type, Print) KFNNFT YNC, SV, JE 34 BALTIM	ore in	D21201.
Sta Registi		31. Date filed (Month, Day, Year) JUL 3 1 2008	32. Registrar's Signature		

10,

State Registrar Allison

31. Date filed (Month, Day, Year)

N. Greene Street Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** 12:15 A M 24, July 2008 Richard Gordon Freudig, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's 1109 Parkington Lane Bowie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 88 Oct. Director 119-09-7026 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Items 23a or 28a-f show any lipiry or other traumatic event, the Medical Examiner must he marked other gone. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 □ No Director Maryland Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20716 USA 1109 Parkington Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: '40-'47 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🗓 No Specify ģ Specify: 3 Widowed 4 Divorced USA Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Compensation Specialist Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rudolph Freudig Mary Ziegler 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1109 Parkington Lane Bowie, MD 20716 Dorothy W. Freudig/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland
Veterans Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 XX urial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/29/2008 | Crownsville, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Adult Failure To Thrive /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Congestive Heart Failure and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 XNatural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours are To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 466665 7/25/2008 92/W27-D0 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 9200 Basil Court #200 Largo, MD 20774 Dr. Dona Leskuski 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

APPIN TIPE Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 08 : 18 PM 0 /Medical 4a. Facility Name (If not institution, give street and number) GENESD 4c. County of Death 4b. City, Town, or Location of Death 21133 Examiner RANDALLSTONAL, MD TARI HEALTH CAPF BALTIMO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 KE Months 6 Director 61 301 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Baltimore MD 1XYes 2 No Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Woodbine Avenue 21207 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 ☐ Yes 2 M No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Domestic 8th grade 17. Father's Name (First, Middle, Last) rmit. Pages 1 and 2 should be flie partment of Health and Mental Hyportant: If Item 27 is marked oth y Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Bagnell Nicholas ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 3714 Woodbine Alenue Battomore MD 21207 Mayess 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or 08/01/08 4 Donation 2 21. Signat e of Funeral Service License Garrison Forest Owings Mills, MD 22. Name and Address of Facilin Vaughn C. Greene Funeral Svcs. auchr ...8728 Liberty Road Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearfailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementi **Physician** /Medical Due to (or as a consequence of) Examiner rebrovas cular accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed the burial-transit eavs erebrovasc and Due to (or as a consequence of) Box 68760 physician Physician/Medical as 1 attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.O. the detached 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. \$ pe , 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate has autopsy performe 2 X No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 20 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital 29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 575 Fair mount Ave Baltimore MD 21204 2 EVEN A. Levenson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician / Medical Brannier Richard Victor Fonzi Sr. School Brannier As. Flainfly Name (if not institution, give street and number) As. City, Town, or Location of Death As. County of Deat		-	State of Maryland / Dep. 1 - State Registrar State of Maryland / Dep.	artment of Health and l artificate of Death	Mental Hygiene Reg. No. 200	18 2460
Richard Victor Fonzi Sr. Family Name (Incertables) per server and number of personal properties of the personal properties of personal properties of the pe	Physicia	n	The state of the s			3. Time of Death
Lorien Bel Air Lori					July 25, 200	8:30 P M
Second Security Number 1.5 Second S	Examin	er		4b. City, Town, or Location of Death	h 4c. County of [Death
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23a. Part l'Entertup disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximation death of the cause (Final International Conservation or subting in death) Physician (Medical Examiner) Part life the type disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximation death of the cause (Final International Conservation or subting in death) Sequentially its conditions. Sequentially its condition	mit. F portar r Inju	Ì				Maryrana
Physician Medical Sacration or complete and a service of the servi	P a m c a			McComas Funeral Ad 1317 Cokesbury Rd	ome, P.A. Abingdon, MD 2	1009
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Manuel Lazath DD Street See Street	To the within to the confine c	M	29b. Signature and title of certifier	DISSES	29d. Date signed (A	Month, Day, Year)
Manuel Lozath MV			30. Name and address of person who completed cluse of death, Item 23a) (Type,	Print Ct	reet. Xhow	Car Pla
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	9 MW 3)		er, why

		,	State of Maryland / Dep	artment of Hea		lental Hygi	ene g. No.20	ΠR	24608
			1. Decedent's Name (First, Middle, Last)	Tillicate of De	aui	2. Date of Deat		00	3. Time of Death
	Physicia /Medic		Margaret Greb			July	2 ^{Day} , 2	OO8	7:45 P M
1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc			4c. County		
6. 3		73.	Renaissance Gardens 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Catons If Under 1 Year If	SVille Under 24 Hrs.	8. Date of Birth	Ba	1timo	
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144	-tay		Usual Residence of Decedent			3,	1,15		
	anylar show	5	10a. State 10b. County 10c. City, Town or I					11	0d. Inside City Limits 1 ☐ Yes 2 No
	the M	Funeral Director	Maryland Baltimore Cate	nsville 10f. Zip Code		1/	g. Citizen of V	Vhat Coun	
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alla	al Hyg	Be C	17. Father's Name (First, Middle, Last)	18	. Mother's Name	(First, Middle, N	laiden Surnam	10)	
<u> </u>	ould to	은	Andrew Geb			ra Balad			
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Dallimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show important: if Item 27 is marked other than "atural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Permation Science	of Facility	of Maryl	and In	c ·	aryrand
٥_	a ii be		Thomas Gregor	299 Frederic	ck Road	Baltimon	re. Mar	vlanc	1 21228
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	He					Onset and Death
	/Medical Examiner		Due to (or as a consequence of):						
H		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
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	To the Hospital or Attending Physician: The law within 24 burns after death. To the Funerial Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 12 Certifying Physician: To the best of my knowledge, de	ath occurred at the time,	date and place,	and due to the ca	ause(s) and ma	anner as s	tated.
	he Ho n 24 h he Fui pletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opin	ion, death occur	red at the time, d	ate and place,	and due to	the cause(s)
	To ti To ti comp	Me	29b. Signature and title of certifier	29c. License nu	umber	2	9d. Date signe	d (Month,	Day, Year)
			((((() () () () () () () ()	124,	141/	`.	1-17	30,	2008
	1		30. Name and address 1 son who completed cause of death (Item 23a) (Typ	Fus ville	Ma	n 7	J-14 (728°	,	
	⊸ Sta	ite	31. Date filed (Month, Day, Year) 2000 32. Figuretra's Signature	locate 1	146	1) 5	100-		
	Registr		JOF 3 T CARO VIENES YOU	STATE OF THE STATE					

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				ryland / Dep	artment of H	lealth and Me	ental Hyg	iene	
			1 - State Registrar	Cei	rtificate of l	Death	Re	eg. No. 2008	21,610
			Decedent's Name (First, Middle, Last)		1 >+1	:	2. Date of Deatl Month		3. Time of Death
	Physici /Medi		Susan Lea	Gr	ay bill		July	2-8 Year 20	08 15:40 M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death		4c. County of Dea	th
			The Johns Hopkins Hospital		Baltimore	City		n	/a
	Funeral			e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day,	year) 9. Bir	thplace (State or Foreign
	Director		176-56-6972 1 □ M 2 🖫 F	48 Yrs.	World Bays	Tiodis Will.	June 16	, 1960 Per	
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	nation				10d. Inside City Limits
	lanyle sho	5	,	,					1 Yes 2 No
	the N 28a-1 otifie	Directo	PA York	_ Wr:	ightsvill	<u>e</u>			
	with t		10e. Street and Number		10f. Zip-Code		10	ng. Citizen of What Co	ountry?
	sath	era	209 Chestnut Street 11. Marital Status 12. Was Decedent E	in III C	1736		K. Van an Na	USA	ata a a la dia a
	Herr ner n	Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 12. Was Decedent E Armed Forces? 1 □ Never Married 2 ☒ Married	lo lo	If Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto Ri	can, etc.)	14. Race - Ame Black, Whit	
99	rs af	A	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify: W	nite
ğ	filed within 72 hours after death with the Maryland Hygiene. Hygiene and Inatural", or items 23a or 28a-f show the Medical Examiner must be notified at	ē	15. Decedent's Education	16a. Dece	dent's Usual Occup	pation		16b. Kind of Business	
75	n "na Aedic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5-	life	kind of work done of DO NOT use retired	during most of working f)	1		
21215-0036	d with	ĕ	12 n/a		mergency 1	Management		Hospi	tal
	othe	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	First, Middle, M	Maiden Surname)	
Maryland	should be and Mental I s marked of umatic ever	2	Edward A. Krouse			Caro1	Α.	Buri	ns
ar	2 sho and M Is ma		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street	and Number or Rural	Route Number,	Cify or Town, State,	Zip Code)
Σ	₽ £ 12 ₽		Thomas A. Graybill, Jr.	209	Chestnut	St., Wrig	htsvill	e, PA 17	368
ore.	es 1 a of He ittem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State	20b. Place of Dispo	osition (Name of matory or other place	Da		20c. Location - City or	
Ĕ	Pag nent int: if		4 □ Donation 5 □ Other (Specify)	Cremation				York, Penn	nsvlvania
altimore,	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		21-Signatur of Funeral Service Licenses		2 Name and Addre				
<u>m</u>	P E E		Bryan W. Clary		10 W. Pa	donia Road	, Timon	iium, MD	21093
	-		23a. Part / . Enter the disease, or complications / hat cau ed sho k, or heart ailure. List only one cause on eac line	the death. Do not ent					Approximate Interval Between
	Physician		Laurente Occur (Elect		hemon	hago			Onset and Death
	/Medical		resulting in death) Due to (or as a	consequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	hage cloid leuk	,		
	Examiner	ايا	Sequentially list conditions, b. relay	bud ac	cute mye	eloid leuk	ema		
7	- =	Examiner	if any, leading to immediate cause. Enter Underlying	consequence of):					
	cutec nd transi	хаш	that initiated events c	Mountor	ena				
o o	e exe ian a iurial-		resulting in death) Last Due to (or as a	consequence of):					
8760,	ifficate be executed g physician and as the burial-transit	edical	d						
	ng pl		IF FEMALE:	. = 3					
õ	The law requires that the death certifie has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 ☐ Live birth	2 Fetal death 3	Ectopic pregnanc	y		23d. Date of de Month	livery Day Year
P.O. Box	e de	ysic	1 ☐ Yes 2 No 4 ☐ Pregnant at 1 9 ☐ Unknown 9 ☐ Unknown	time of death 5	Other (specify)				Suy Tour
<u>7.</u>	nat th		Part II. Other significant conditions contributing to death but	at not resulting in the a	inderlying cause di	ven in Part I	23e Did toh	acco use contribute t	o the cause of death?
Š,	res th	i by	3		g		1 \square Yes		robably 4 Unknown
Ö	requi	etec							
ě	ne law has b ge 2 s	Completed					24a. Was an autopsy perform	/ prior to	utopsy findings available completion of cause of
_	- m							No 1 ☐ Yes	2 🗌 No
Vital Records,	ysiclan: The scertificate director, pa	Be	25. Was case referred to medical examiner?		Othe	26. Place of Death (0			
ō	Phys this c	<u>ا</u>	1 ☐ Yes 2 ☐ No Prospital: 1 ☐ Inpatien 27. Manner of Death 28a. Date of Injury		it 3 🗆 DUA	4 LI Nursing Home		nce 6 Other (Spec w injury occurred	cify)
Division of	ding After fune	ertification:	1 Natural 5 Pending (Month, Day 2 Accident investigation	Year) Injury	Work	?	a. Describe no	w Injury occurred	
	kttendi death ctor: A y the f	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injur	y - At home, farm, str			f. Location (Str	reet and Number or R	ural Route Number
=	F # E C	erti	4 Homicide determined building, etc.		, , , , , , , , , , , , , , , , , , , ,		City or Town,		,
	spita spita nours neral fillec	a C	29a. Certifier 1 Certifying Physician: To the best of	my knowledge, death	occurred at the tin	ne, date and place, an	d due to the ca	ause(s) and manner a	s stated.
	e Ho e Fur	Medical	(check only one) 2 Medical Examiner: On the basis of and manner state	examination and/or in led.	vestigation, in my o	pinion, death occurred	d at the time, da	ate and place, and du	e to the cause(s)
	To the Hospital of within 24 hours at To the Funeral D completely filled i	Me	29b. Signature and title of certified		29c. License		29	d. Date signed (Mont	h, Day, Year)
			> 10MVV M	.D .	RES	5-000	;	7/28/08	S
	17		30. Name and address of person who completed cause of de	eath (Item 23a) (Type,				·	
	10		Sharm Kim M.D.			600 No	orth Wolf	e St, Baltimo	ore, MD, 21287
	Sta		31. Date filed (Month, Day, Year) 32. Begistrar		9				
	Registr	ar	JUL 3 1 2008 Degree	s 18 Ro	ach!				

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:05 A.M Irving J. Guilfoy July 27 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1869 Potomac Road Pasadena 6. Sex 1 M 2 ☐ F if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 81 215 22 3713 Director Maryland 08/17/1926 Usual Residence of Decedent with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d 2 should be filed within 72 hours after death with th and Mental Hygiene.
7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 1527 Long Point Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Tate Dodge 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irving G. Guilfoy Blanche Soustek ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health ant: if item 27 i Janice Pazdersky / Daughter 38 Mansion Road Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State injury or permit. Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Cedar Hill Cemetery 08/01/2008 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licens 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the disth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final laucer **Physician** Metasta disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sequence of the case Due to for as a consequence of: Examine the death certificate be executed the burial-transi attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy Day Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an this certificate has ral director, page 2 autopsy 1∏ Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Daughter's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Home Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) W.D. 2008

Registrar

DHMH 17 Rev 1/2001

State

30. Name

31. Date filed (Month, Day, Year)

JUL 3

1 2008

intain Rd Pasadena md 2/122

and address of person who completed cause of death (Item 23a) (Type, Print)

3

92. Registrar's Signature

708

Amend 19a, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:15 PM Glenn JUL 28 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner OSPITAL RANDALISTOWN Baltimore hwest If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
OCT 12, 1951 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 X M 2 □ F 217-54-4339 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Owings Mills MD Baltimore 1 ☐ Yes 2X No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1 Old Coach Lane Apt 2D 21117 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Express Agency Environmental Worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clemit Odell Glenn Mattie Goins 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis A. Glenn Šř. – Son 2555 Arunah Avenue Baltimore, MD 21216 permit. Pages 1 and Department of Healt Important: If item 27 any injury or other 1 once. or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Crematory 1 AUG 08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Si na ure o Funeral Servi a Licens John L. Williams Funeral Directors, P.A. 1701 McCulloh St. Baltimore, MD 21217 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) IN FAR CTION MYOCARd **Physician** /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, frank leading to influence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examiner physician and the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. cate has been signed by the page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 100 24a. Was an autopsy 1□ Yes 2 X No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA 1M∑Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certilie 29c. License number 29d. Date signed (Month, Day, Year) 2 D0054558 30. Name and address of person to completed cause of death (Item 23a) (Type, Print) 5401 Old Court Rd RANDALISTOWN, MD velle, TR, mo 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

		-	For State	State of M	•	epartment of		nd Mental Hy	giene Reg. No. 20	nα	21.613
.36			Registrar 1. Decedent's Name (First, Middle, I	.ast)	4	Certificate 0	Dealli	2. Date of De		00	3. Time of Death
	Physici /Medic	an	Richard 1	Justin	GORdo	2		Month	Day 232	Year	10:50 AM
	Examin		la. Facility Name (If not institution, c)	4b. City, Town	, or Location of	Death	4c. County	of Death	
		Ä		A Medica	L Cente	R BAL	HMORO ar If Under 24		N/	2 Pinthala	(Otata Familia)
1	Funeral Director		5. Social Security Number 6 218-64-0848	Sex 7. A	ge (In yrs. Iast birti	rs. Months Day		Min. (Month, Da	y, Year)	Countr	ce (State or Foreign y) YLAND
#	1871 MATE		Usual Residence of Decedent					10-20	-1750		
	arylan show dat	٦	10a. State 10b. County N/A		10c. City, Town	or Location				100	d. Inside City Limits 1 [XYes 2 □ No
	death with the Maryland Hms 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number		DILLI	10f. Zip Cod	Α		10g. Citizen of V	What Countr	v?
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	death	nera	11. Marital Status	12. Was Deceden		13. Was Decedent	of Hispanic Origi	n? (Specify Yes or No Puerto Rican, etc.)	14. Rac	e - Americai	
98	hours after death with the Marylar tural", or Items 23a or 28a-f show M Examiner must be notified at	by Fu	1 Never Married 2 Married	1 □XYes 2 □ If Yes, Give	No	1 ☐ Yes 2 1				BLAC	
5-0036	hours tural	q pa	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:		Decedent's Usual Oc	cupation		16b. Kind of Bu	usiness/Indu	stry
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nd	be file	Be	17. Father's Name (First, Middle, La	st)				s Name <i>(First, Middle</i> ARY RICE	, Maiden Surnan	ne)	
Maryland	2 should be and Mental is marked of aumatic ev	၉	EDWARD GORDON 19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (Str		or Rural Route Numb	er. Citv or Town.	State. Zip (Code)
	s 1 and 2 should be filed within 72 hours aft of Health and Mental Hygiene. Item 27 is marked other than "natural", or other traumatic event, the Medical Examilation.		VICKY FRANKLIN		I			E. BALTIMO			
Je,	es 1 and of Health item 27	Ì	20a. Method of Disposition	Dameural from Chak	cometer	Disposition (Name of y, crematory or other	olace)	Date	20c. Location -	City or Tow	n, State
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Baltimore,	permit. Pages Department of Important: If it any Injury or once.		21. Signatur Service	AHTANOL Sen	CB HIBI		-	PHILLIPS F OE ST. BAL		-	
	4		23a. Part1. Enter the disease, or co shock of heart failure. List or	omplications that cause	ed the death. Do n	ot enter the mode of	dying, such as c	ardiac or respiratory a	ırrest,		Approximate Interval Between
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	uted d ansit	Examiner	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Hen	atic.	Circho.	sis	Periton			
,160,	be executed sician and burial-transit		resulting in death) Last	Due to (of a	s a consequence of	of):					
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Box 6	he law requires that the death certificat e has reen signed by the attending phy ige 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d. Da	ite of deliver	v
	death e atter	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	2 Fetal death at time of death	3 ☐ Ectopic pregna 5 ☐ Other (specif)			Mo	onth [Day Year
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>	disi y	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 1 Inpai	tient 2 ER/Ou	patient 3 DOA	Other: 4 Nur	sing Home 5☐Res	idence 6 □Otl	ner (Specify))
Division or	Jing Pt n. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D			njury at Work?		how injury occur	rred	
isio	death. ctor: / y the f	icati	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	be 290 Place of it	niury - At home, fa	m, street, factory, off	I □ Yes 2 □ N		(Street and Numi	ber or Rural	Route Number.
Div	al or Atten after death Director: d in by the	Certification:	4 ☐ Homicide determin	building,	etc. (Specify)	,,,,			wn, State)		,
	To the Hospital or Atte within 24 hours after des To the Funeral Directo Completely filled in by the		29a. Certifier 1 Certifying	Physician: To the bes	at of my knowledge	, death occurred at the	e time, date and	f place, and due to the	cause(s) and m	anner as sta	ated.
	To the He within 24 To the Fu	Medical	one)	and manner s	stated.						
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2+	1 61	1	30. Name and address of person w	no completed cause of	death (Item 23s) /	Type Print)	2133		UT-23	ال ال الله الله	
7			Thomas J. Merkle	M.D.	dodin (nom 20d) (IONORTH	GREEN	e Street	Baltino	Re MI	21201
	Sta		31. Date filed (Month, Day, Year)	2008 32 Regis	trar's Signature	Coords		e Street			
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Quinton Hosan 08-05697 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 24614

		For State Certificate of Death Reg. No.							_ , _ ,						
Physicia		Decedent's Name (First, Midd	lie,Last)							Date of Dea Month	ath Day	Year		me of Death	
edical Éxamiı	ner	Ouinton		E110	gene		Н	oqa	an	_ j	uly 25, 2	2008	i cai	10	025 hrs
		4a. Facility Name (if not instituti	on, give stree	et and number)	900	41	. City, Town			Death		4c.	County of	Death	
		Sinai Hospital					Baltimore	Э							
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last b	irthday)	If Under 1	_	If Under	_	. Date of B	irth(MM/I	DD/YYYY)	9. Birthplac Foreign	e (State or
Director		220-08-3000	1 X M	2 F	23	Yrs.	Months [Days	Hours	Min.	05	05	85	Country)	MD
	ŀ	Usual Residence of Decedent								<u> </u>					
à	ŀ	10a. State 10b. County		-	10c. City, Tow	n or Locatio	n							10d.	Inside City Limits
_ 0M		WD D-3				Day	kvil.	1 ~						1	Yes 2 _x No
yland -f sh	ğ	MD Bal	timo	re		Pal	10f. Zip Coo				— т	10o Citi:	zen of Wh	at Country?	
ne Maryland or 28a-f show any fied at once.	ē								234		ŀ	109. 0		S.A.	
ith the Maryland 23a or 28a-f sho notified at once.	Funeral Director	30 Solar Cir													
ms 2	era	11. Marital Status		Was Decedent I Armed Forces?	Ever in U.S.		Decedent of s, specify Cu					0-	14. Race White	 American Ir etc. 	ndian, Black,
deatl	اڃ	A	1	Yes 2	X No						,			Blac	ale
after aff.,	by	3 Widowed 4 Di	vorced If Yes	, Give Year tes:			Yes 2 X						Specify:		
5-0036 led within 72 hours afte tygiene. other than "natural"; the Medical Examiner	ğ	15. Decedent's Education (Sp		hest grade com	pleted) 16a	a. Decedent	s Usual Occ st of working					16b. k	Kind of Bus	siness/Indust	ry
72 h	Completed	Elementary/Secondary (0-12)	college (1-4 or 5	(+)						,		T 7		d
036 ithin 72 in than r than	ם	9th grade		na		l	Jnemp	_				<u> </u>		emplo	oyeu
5-00 led wit Hygien other	ပိ	17. Father's Name (First, Middle								,	rst, Middle				
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medics	Be	Maynard He	ndick								e Ho				
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Montal Hygienel. ten 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once.	٩	19a. Informant's Name/Relation			1178									n, State, Zip	
and 2 shoulealth and 1 tem 27 is traumatic		Catherine Ho	ogan-	Mother										lle,	
e, MC I and 2 sl Health ar Fitem 27 r frauma	- 1	20a. Method of Disposition				e of Disposi natory or oth		of ceme	etery,	D	ate	20c.	Location -	City or Town	n, State
2 8 4 = 8		1 X Burial 2 Cremation		emoval from Sta	ile i	rkwoo				8/2/	′08	Pa	rkvi	lle,	Md
Baltimore, permit. Pages I an Department of He Important: If ite	H	4 Donation 5 Other 3	Specify: e Licensee				ame and Add	dress	of Facility						
Balti permit. Departm Imports injury o	J. J	X	1-a A.	- Ine	_)	Man	ch F	/H	Wes	t	D = 1 4	·		M = 1	21215
Physician		23a. Part I. Enter the disease, of	or complication	ons that caused	the death. Do	not enter th	e mode of dy	na. ying, s	uch as ca	ardiac or re	espiratory a	rrest, sho	ock, or hea	art Ap	proximate Interval
/Medical		failure. List only one caus	e on each lir	e.										Be	etween Onset and Death
⊤xaminer	11	Immediate Cause (Final diseas or condition resulting in death)		shot Wound		orso		_			_	_	_	_	
			h	o (or as a conse	squerice or).										
	ē	Sequentially list conditions, if any, leading to immediate	Due t	o (or as a conse	equence of):										
	Ë	Cauce. Enter Underlying Cauc (Disease or injury that initiated	C.											-	
E P. 15	Examiner	events resulting in death) Last		o (or as a conse	equence of):										
executed an and al - trans			d												
760, icate be ex physician the burial	//Medical	UNPENDED	III AM	ENDED									_		
3760, ficate be g physicia s the burit	Ĭ,	IF FEMALE: 23b. Was decedent pregnant in		c. If yes, outcor		су		2	Fatania	pregnanc	.,	23	d. Date of Month	delivery Day	Year
68 certif nding se as	ian	past 12 months?	14	Live birth Pregnant at	time of death		al death ner (Specify)		Ectopic	, pregnanc	У	- 1	WOITH	Day	7001
Box 687 ne death certifice the attending part of the ast	Physiciar	1 Yes 2 No 9 U	nknown 9	Unknown		5 Oti	ier (Specify)	_							
the d	Ph	Part II. Other significant cond	litions conf	ributing to deat!	n but not resu	Iting in the u	nderlying ca	use gi	ven in Pa	ırt I.	23e. Dio	tobacco	use contr	ibute to the o	cause of death?
ires that the designed by the signed by the lack detached is the detached in t	ð										1 N	es 2	√ No 3	Probably	4 Unknown
ords, w require s been sig	Completed										1 24a. Wa	as an	24b. \	Were autops	y findings available
Orc aw re as be	ble											opsy formed?		prior to comp death?	letion of cause of
Rec The la	Eo										1 🗸 Yes			✓ Yes	2 No
tal Rec rian: The certificate ector, page	Be C	25. Was case referred to medi-					26.	Place	of Death	(Check on	ly one)				
Vita ystci his c	0	examiner? 1 ✓ Yes 2 No	Hospi	tal: 1 Inpatie	ent 2 🗸 EF	₹/Outpatient	3 DOA	,	Other4	Nursing !	Home 5	Resid	ence 6	Other:	
Division of Vital Records, tal or Attending Physician: The law requints after cleah. In Director: After this certificate has been siled in by the funeral director, page 2 should I	-	27. Manner of Death		28a. Date of Inju		b. Time of I	njury 28c	. Injur	y at Work		8d. Describ ubject w			red	
On endir ath.	ᇋ		nding	Jul 25, 2008	0	945 hrs	1	Y	es 2 🗸	No S	ubject w	a5 5110			
isior Attender death	ica		estigation under the	28e. Place of In	jury - At home	e, farm, stree	et, factory, of	fice bu	uilding, et	c. 2	8f. Location	(Street	and Numb	er or Rural F	Route Number, City
tal or rs aft led ir	Certification:		termined	(Specify) Ma	ijor Road /	Highway				55	or Town 500 Waba	i, State) ish Aver	nue, ,		
fospi 4 hou uner	Ö	29a. Certifier	Physician:	To the best of m	v knowledge.	death occur	red at the tin	ne, da	te and pla	ace, and di	ue to the ca	ause(s) a	nd manne	r as stated.	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certificate but on the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral directors.	edical	(Check only one) 2 Medical E	caminer:On	the basis of exa	mination and/	or investigat	ion, in my op	oinion,	death oc	curred at t	he time, da	ite and pl	lace, and	due to the ca	use(s)
To To	Med	29b. Signature and title of cert		manner stated.			29c. L	icense	e number			29d	. Date sign	ned (Month,	Day, Year)
_	-			1 /	1			D.C.N	И.E.			Jul	y 26, 20	800	
			YN	V11/1		1-1						l			
2		30. Name and address of pers		leted ca e of o ef Medical E			n Street,	Balt	imore	MD 212	01				
					.4.2		49			1410 212	J 1				
	tate	11 1	131		ir's Signature	J.	Sports	م							
Regis	146.11	₩ W	ARR A7 168		-W		6"								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 27^{ay} 2008 **Physician** 1:15 PM Patricia A. Harrington /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Jan 17, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1941 Funeral Months Days Hours 1 ☐ M 2 🗓 F Massachusetts Jan 033-30-5782 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exercipes must be notified as once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Crownsville Funeral Director Maryland | Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21032 809 Vine Street Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Anne Arundel County Crossing Guard 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Rieser John P. Fleming ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 809 Vine Street Crownsville, Maryland 21032 William Harrington, Husband 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/29/08 Baltimore, Maryland Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Q P515 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DYEV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter of be detached for u Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Yes 2 🗆 1 ☐ Yes 2 🖼 🗖 🗸 2 🗆 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Hospital: 24 No 1 npatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury at Work? 27. Manner of Death After Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month/Day, Year) 29c, License number 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

Year)

32. Registrar's Signature

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AND THE CONTROL OF 2008 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 28, **Physician** 6:05 PM 2008 Jendolyn /Medical 4a Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Assisted louch indsor h. Ving 7. Age (In yrs. last birthday)
Yrs. 6. Sex Social Security Number **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. Director Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the fleatical Examinar must be notified at once. 1 ☐Yes 2 No Director lair 10f. Zip Code 10g. Citizen of What Country? 21015 2107 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Was Decedon. Armed Forces? 1 □Yes 2 No Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 📉No Specify. 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) leacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Be ပ nber, City or Town, State, Zip Code) 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number 2107 Belair 21015 Joseph Treston Baltimore, Medford od of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State 8.2.2008 eene Funeral Services 21. Signature of Tuneral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infarction Physician Myocardia /Medical Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of sician and burial-transit n The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Mo Month Day Year 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No this certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Hospital 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA ۵ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 14 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D15938 7129108 YUNYONGFING M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALINEE Old Rel # 201 5400 Randallstom Mol 21133 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hydiene

		1	State of Maryland 1 - State Amend Item 24a per verb	- , 6881 07/31/16	eaith and ivie 8dhb Eath	ntai Hygie Reg	2008	24617
*	Physicia		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death 2:05 PM
	/Medic	al .	Dorothy T. Haughton 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or		July 1	8 200 8 4c. County of Death	
#	Examin	er	Dorchester General Hospital		idge		Dorch	ester
	Funeral Director		5. Social Security Number 408-34-3555 6. Sex 1 □ M 2 7. Age (In yrs. last) 91		Hours Min.	B. Date of Birth (Month, Day, Y) an 19,	ear) Cou	pplace (State or Foreign untry) 110
	and w		Usual Residence of Decedent 10a, State 10b, County 10c, City, T	own or Location				10d. Inside City Limits
	Maryla f sho	ro	MD Howard	Jessup				1 □Yes 2x No
	n the r 28a.	Director	10e. Street and Number	10f. Zip Code		10g	. Citizen of What Co	untry?
	ath wit 23a c ust be	ralD	9950 Guilford Road	10 11 5 1 1 1 1 1	20794	if y Vac or No	USA 14. Race - Amer	ican Indian
200	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Hean 27 Is marked other than "natural", or items 23a or 28a-f show then 21s marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 21 No	spanic Origin? (Speci n, Mexican, Puerto Ri Specify:	ican, etc.)	Black, White	e, etc.
5.5	nin 72 hou s. In "natura Medical E	Completed	(Specify only highest grade completed)	16a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	ation during most of working)	7	6b. Kind of Business/	ndustry
7	ould be filed with Mental Hygiene. arked other thar atic event, the M	Com	12 0	claims adju	ister 18. Mother's Name ((Eirat Middle Ma	insuranc	e
	be file	Be	17. Father's Name (First, Middle, Last) Gordon Alexander Turner		Lois Alvar			
<u> </u>	should ind Men s marke umatic	ည		19b. Mailing Address (Street				?ip Code)
Ě	and 2 sho ealth and n 27 Is ma er trauma		Pat Pannucci/daughter	107 Hambrook	Avenue Cam	bridge,	MD 21613	
more,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Hemoval from State 4 ▼ Donation 5 ☐ Other (Specify)	ce of Disposition (Name of netery, crematory or other plac	Da	ite 20	Oc. Location - City or	Town, State
Dallillo	permit. Departm Importa any inju		21. Signature of Funeral Struce Vicensee Wade, Intector	22. Name and Address State Ana	MD 2120	1		Street
			23a. Part Enter the disease or complications that caused the death. shock or heart failure. List only one cause on each line.	Do not enter the mode of dying	ig, such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death) a. Due to (or as a conseque					
	Examiner	Ļ	Sequentially list conditions, b. Due to a consequent	re Heart	- Failu	re		
	ted sit	Examiner	Sequentially list conditions, if any, leading to financiate cause. Enter Underlying Cause (Disease of Injury that initiated events	- Antern	Disea	se		
ŕ	icate be executed physician and s the burial-transit	Exar	that initiated events resulting in death) Last Due to (or as a conseque	ce of):				
8/PU	tte be tysicia ne bur	edical	d/					
٥			IF FEMALE:	-			20d Data of da	
.O. Box	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as:	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes ≥ No 9 □ Unknown 23b. (If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of deal 9 □ Unknown	leath 3 ☐Ectopic pregnancy			23d. Date of de Month	Day Year
Ţ	w requires that the de been signed by the a should be detached	by	Part II. Other significant conditions contributing to death but not result Acutz Percel Failure	ing in the underlying cause giv	en in Part I.			o the cause of death? robably 4 Unknown
Hecords,	Physician: The law req this certificate has beer al director, page 2 shou	Completed	Acute Penel Failure Hypothyrordian			24a. Was an autopsy perform 1 Yes 2	24b. Were a prior to death?	utopsy findings available completion of cause of
Vital H		Be C	25. Was case referred to medical examiner?		26. Place of Death			
- -	hysic his ce il direc	To E	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 DOA Oth	4 □ Nursing Hon		nce 6 Other (Spe w injury occurred	ecify)
ב	ing P After t funera		1 Natural 5 ☐ Pending (Month, Day Year)	28b. Time of 28c. Injury Wor 1 □	ryat rk? Yes 2 □ No	esa. Describe no	w injury occurred	
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, it	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home building, etc. (Specify)	ne, farm, street, factory, office		28f. Location (Str City or Town,	eet and Number or Fi , State)	ural Route Number,
	e Hospita 24 hours e Funeral etely fillec	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my know and manner stated.	ledge, death occurred at the ti on and/or investigation, in my	me, date and place, a opinion, death occurre	and due to the ca ed at the time, da	tuse(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	29c. Licens	se number	29	d. Date signed (Mon	th, Day, Year)
	-		I Christe & France	<i>D</i>	66371	,	July 18	5 200 8
			30. Name and address of person who completed cause of death (Item Christme To was 300 B	29a) (Type, Print)	nbn dg	c Ma	ryland	21613
	St Regist	ate trar	31. Date filed (Month, Day, Year) 37. Registrar's Signate	me				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician TAMMY HIEDACAVAGE 15:15 JULY 23 2002 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL HARBOR BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F 43 Nebraska Director 199 60 9644 11/14/1964 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: if item 23a or 28a-1 shov any injury or other traumatic event, the livetical Examinar must be notified at 1 ☐ Yes 2 X No Directo Anne Arundel Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21225 U.S.A. 613 Hammonds Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Flooring 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leo Hiedacavage Mary Ann Schmidt ္ရ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Exeter, Pennsylvania 18643 117 Grant Street Christine Kennedy / sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/26/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 snameroushe 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final Physician PROBABLE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by MULTIPLE SCLEROSIS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending illed in by the fi investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: / 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 000 RES JULY 25. 2008

DHMH 17 Rev 1/2001

State Registrar STREET

KAHNTROFF

21225

BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHANIE

32. Registrar's Signature

HANOVER

SOUTH

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month July 2008 Sylvia Lee Campbell Hennessey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center @ GBMC Baltimore If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F Days Hours Director July 9, 242-66-3096 65 North Carolina 1943 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County **Funeral Director** 1 ☐ Yes 2 No Bel Air Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Dixie Drive 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 (XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hardward & Industrial Elementary/Secondary (0-12) College (1-4or 5+) Mill Supplier Treasurer Secretary / 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Donald Folk Campbell Jr. Julia Alice Carlisle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Dixie Drive, Bel Air, MD 21014 John H. Hennessey / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp: 7-26-08 Towson, Maryland 21. Sig 22. Name and Address of Facility

McComas Funeral Home, P.A. ture of Funeral Service 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or his challenge. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AVIAN **Physician** ear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' □Yes 2 **☑** No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending investigation ours after death.
nera! Director: A 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral Completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 24 2108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

V

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GAMC

6701

32. Registrar's Signature

R:

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7-29-2008 **Physician** 8:20A Kathleen J. Ireton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Balto. Gilchrist Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-10-1947 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. Md. 213-52-8683 Director 60 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the theological Examiner must be notified at 1 □ Yes 2 No Md. Abingdon Harford Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21009 IISA 1241 Splashing Brook Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married Married Specify: White 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) الله filed win. ۱۳۰۰ Hygiene. ۲۰۰۰ than ۳۰۰۰ Elementary/Secondary (0-12) College (1-4or 5+) Balto. Co. Public Schools 12 Secretary alth and Mental Hygin 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Giblin Madelyn Ritter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1241 Splashing Brook Dr. Abingdon, Md 21009 Joseph Ireton Husband or other permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 8-1-2008 Balto. City Bayview 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Picensee 22. Name and Address of Facility Schimunek Funeral home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on e at line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 15 /Medical Due to ("r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760 been signed by the should be detached Kati has certificate completely filled in by the funeral director, After this To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A

28a-f show

Maryland 21215-0036

Baltimore,

200

1 and 2 s Health a

State Registrar

DHMH 17 Rev 1/2001

Medical

2. Registrar's Signature 31. Date filed (Month, Day, Year) 2008 JUL31

30. Name and address of person who completed cause

of death (Item 23a) (Type, Print)

29c. License number

025205

Charles St. bolto. Md 2,204

29d. Date signed (Month, Day, Year)

Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7-15-2008 Carol Ann Jones 8:47P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Prince George Tacoma Park if Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1-30-1963 Birthplace (State or Foreign Country) 1 □ M 2 🔀 F 45 073-60-0772 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits _BElkridge Howard Md. 1 □Yes X□No 10f. Zip**2°1'0**75 10g. Citizen of What Country? 10e. Spingd Nemberter Dr. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Veterinary Hosp. Admin. Animal Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Hall Diane Marimow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2711 Arbutus Avenue Halethorpe, Md. 21227 Andrew Jones Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Ki Cremation 3 ☐ Removal from State Bayview 7-18-2008 Balto. City 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home John Cannella PER DVR 9705 Belair Rd. Nottington, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Clays Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Due to (or as a consequence of): Coronary Artery Disease Years Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diabetes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 2. No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28h Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier l 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Physician /Medical or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the this

Examiner the s after death.

I Director: After this of in by the funeral d To the Hospital or within 24 hours aft To the Funeral Di completely filled in

by Physician/Medical Examiner

Completed

Be

Certification: To

Medical

Physician

/Medical

Examiner

Funeral Director

Completed by

Be 10

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-1 ehrer any injury or other traumatic event, the Medical Exercises.

State

Registrar DHMH 17 Rev 1/2001

David M. Brill, MD

29b. Signature and title of certifier

(Check only one)

264

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7901 Maple Ave. Tacoma Park, Md. 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 () 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 31 AM 30 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Hours | Min. | (Month, Day, Oath J.) Baltimore 205 Ce Birthplace (State or Foreign Country) 5. Social Security Number If Under ge (In yrs. last birthday) **Funeral** 1□M 2**以**F Months 213-76-4681 50 **Director** and Usual Residence of Decedent death with the Maryland 10h. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the "Actical Examinat must be notified at 10d. Inside City Limits Director 1 **1 √200** 2 □ No Limore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21205 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 <u>ک</u> 1 ☐ Yes 2 No Specify Black 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any linky or other traumatic event, otde. Be 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname) P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 Baltimore, 20a. Method of Disposition 20b. Place of Disposition cemetery, crematory 1 💢 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 21. Signatore of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused in death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran-Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 **X** No Month Year Day Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2X No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 MOther (Specify) HOSPICE 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 □ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hedicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SOOS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For	Type or Print in Black State of Maryland	l / Depa	artment of F	lealth and N	lental Hy	giene	_
F	hysicia		1 - State Registrar 1. Decedent's Name (First, Middle, La PAUL EDWARD JU	,	Cei	rtificate of	Death	2. Date of Dea	Reg. No. 200 ath 19, Day 2008	3. Time of Death
pa ²	/Medic Examin		4a. Facility Name (If not institution, given MANORCARE NURS	ING CENTER		BALTI			4c. County of D	Death
Di	ineral rector		5. Social Security Number 217–20–3787 Usual Residence of Decedent	Sex 7. Age (<i>In yrs. la</i> 84	st birthday) Yrs.	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 9-17-19	th 19.24 NC	Birthplace (State or Foreign Country) CAROLINA
the Marylan	28a-f show	rector	10a. State 10b. County MD • N/A 10e. Street and Number		Town or Lo				10g. Citizen of What	10d. Inside City Limits 1 ★Yes 2 No
filed within 72 hours after death with the Maryland Hygiene.	ral", or items 23a or 28a-f sho Examiner must be notified at	Funeral Director	301 McMECHAN S	12. Was Decedent Ever in U.S Armed Forces?	. 13.	2121	. 7 Hispanic Origin? (Sp an, Mexican, Puerto		USA 14. Race - A	American Indian,
72 hours aft	"natural", or	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's E (Specify only highest gr.	1 Tes 2 No If Yes, Give Year or Dates: ducation ade completed)	16a. Dece	1 Yes 2 No	during most of work	ing	Specify: E	
be filed within ntal Hygiene.	if item 27 is marked other than "natur or other traumatic event, the Medical	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last	College (1-4or 5+)	life.	DO NOT use retired ORER	18. Mother's Nam	e (First, Middle,	EASTERN S	STAINLESS STEE
d 2 should be th and Ment	7 Is marked traumatic e	10	TOBIE JUDD 19a. Informant's Name/Relationship (KENNETH JUDD (S			-	and Number or Rui		er, City or Town, Sta	
Pages 1 and ment of Health	ant: if item 2 ury or other		20a. Method of Disposition	Removal from State	ce of Dispo metery, cren	sition (Name of natory or other place	7-2	Date 5-2008	RE, MARYLA 20c. Location - City OWINGS MII	
permit. Pag Department	important: i eny injury o <u>once.</u>		21. Signature Funeral Service Lice 23a. Part / Enter the disease, or com	U. Husz	~ 1	721-27 N.	MONROE S	ILLIPS D	FUNERAL HO	OME, P.A. ARYLAND 21217 Approximate interval Between
/Me	sician edical miner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseque	ence of):	espirati	Day And	St	s # 0	interval Between Onset and Death
pe e	/sician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) C. Due to (or as a consequence)	nce of):	omyos	ign (omi	G G	ynų.	
The law requires that the death certificate	y the attending physician iched for use as the buria	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal (4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	☐ Ectopic pregnance ☐ Other (specify) _	y		23d. Date of Month	f delivery Day Year
equires that	as been signed by the 2 should be detached	by	Part II. Other significant conditions	bontributing to death but not result	ting in the u	nderlying cause giv	en in Part I.		obacco use contribut Yes 2 ☐ No 3 ☐	te to the cause of death? Probably 4 Unknown
	ate h	Completed	OF Who approved to medical					1 🗆 Yes	psy prior deat 2 2 2 10 1	
nystcia	directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ inpatient 2 ☐ E	R/Outpatier	nt 3 DOA Oth	26. Place of Deat er: 4 Nursing Ho		one) dence 6 □ Other (Specify)
To the Hospital or Attending Physician: within 24 hours after death.	tor: After the the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	(Month, Day, Year)	28b. Time of Injury	M 1 □		28d. Describe l	how injury occurred	
pital or Al	eral Direc		4 Homicide determined				me data and place	City or To	wn, State)	or Rural Route Number,
o the Hos	ompletely	Medical	(Check only one) 2 Medical Example one) 29b. Signature and title of certifier	miner: On the basis of examination and manner stated.	on and/or in	vestigation, in my o	opinion, death occu	red at the time,	date and place, and	due to the cause(s)
$\left(\frac{1}{2} \right)^{2}$	\		30 Name and address of person who	ompleted cause of death (Item)	23a) (Type.	DS Print	7625	(July 23	2008
2,			Kouch Dago	th Chips 300 +	4mar	Mace, St	cho, ba	Himore	, MD	2121
_	Sta Registra	ar	31. Date file (Month, Day, Year)	32 Tegistrar's Signatu	ire	orles	ŧ		1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07-25-2008 **Physician** 832 P M James Robert Krebs /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Towson 9. Birthplace (State or Foreign Country)
MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 08-08-1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Days 1 ₹ M 2 □ F Months Hours 218-26-8998 78 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mexical Examiner from the results at 1 ☐ Yes 2 ☐ No Directo Harford MD Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 111 St. Mary's Church Rd 21009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Force
1 XYes 2
If Yes, Give be filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 💢 No Specify. ģ Specify: White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Letter Carrier Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ira Harry Krebs Elsie Mock ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 St. Mary's Church Rd Abingdon, MD 21009 Audrey Krebs (Wife) permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once. altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State 07-29-2008 Highview Mem. Gar. Fallston, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ungcana Immediate Cause (Final **Physician** er -- Squamous disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-tra resulting in death) Last Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an , page 2 autopsy performed? of Vital 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours a er death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) TowsentownBlud 0 . Haulkner

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 () () 8 Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** 25, 9:55 AM Estella (NMN) Kessler July 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Harford Havre de Grace If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Director 1916 North Carolina 92 218-40-7801 Apr. Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Dotson Drive 21911 USA Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No ò 3 ➡Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) oe filed with.
All Mental Hygiene.
S marked other the Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Health and Mental George Washington Triplett Claudia Rebecca Dav 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 87 Nice Road, Halifax, Pennsylvania, 17032
Disposition (Name of Date 20c. Location - City or Town, State June E. Borger / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 'Department of H Important: If ite any injury or of 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 7/30/2008 Bel Air, Maryland re of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or tead failure. List only one cause on each line. Immediate Cause (Final Myocardia Litaration **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ON. OVONOVY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box (IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a o. 9☐Unknown 9 ☐ Unknown signed by 1 Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 2 No 3 Probably 4 Unknown 100 1 🗌 Yes Completed Fleva 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA ပ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D-0033925 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rising Sun Queen Street MD Thresher 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 3 1 2008 Registrar

DHMH 17 Rev 1/2001

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 5:45 PM LEATRICE JULY DELURES LEWIS 2008 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERA (HUSPITAL Corumsia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director 219-26-5587 12 04 37 70 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Inten 27 is marked other than "natural", or Items 23a or 28a-f show r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No Director MD Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Row other traumatic event, the Medical Examiner must be 21045 8831 Flower Stock Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Federal Government 6th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Constancia Harper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8831 Flower Stock Row, Columbia, Md 21045 Cheri Lewis-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 7/30/08 Baltimore Co, Md any injury Woodlawn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md laham 21215 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC **Physician** SITZUCK 2 WEEKS /Medical Due to (or as a consequence of): **Examiner** BACTERGMIA 4 WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine 6 WEGILS PNEUMONIA burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760_c^{μ} Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Year Day 5 Other (specify) 9□Unknown 9 ☐ Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ · UNINARY TRACT INFECTION · RESPIRATING FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed · CHRONIC REMAN · DEWBITUS ULCER 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ►No 24a. Was an autopsy performed? ANGMIA 2 ☐ No ospital or Attending Physician: Thours after death.
uneral Director: After this certificate if filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Nnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 ☐ Yes 2 No ဥ 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

amend item store permarihana 881 bepartment of Health and Mental Hygiene

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

an motivayon. O a wall

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

BROWN

10724 LITTLE PATURENT PANEWAY

29c. License number

036974

29d. Date signed (Month, Day, Year)

Corumbia MO 21044

JULY 23, 200B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Ursula E. Libonate 07-24-2008 11:50 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Towson 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔽 F Months Days Hours Min. Director 65 06-21-1943 218-46-4252 Germany Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experiment results be notified at 1 □Yes 2X No Funeral Director MD Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 F Ciderpress Ct USA 21085 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. þ Specify: White 3 Widowed 4 Divorced al Hygiene. Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser Cosmetology Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event, once land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johann Gostol Franzesca Gostol 2 Maryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Libonate (Son) 1962 Dora Ave. Walnut Creek, CA 94596 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 07-29-2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signalure of Forneral Services Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Concer Nulashan c to bring **Physician** - Small Cell montal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): 68760, physician Physician/Medical the attending p Вох IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached Ö 9 Unknown ۵, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performa Vital 1 ☐ Yes 2 🗆 No 1 ☐ Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSPUL 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To o 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury Division 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008

Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

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Chares

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANNES

W

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 25, ^{Day} 2008 **Physician** 3:10 Pauline M. Layman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hyattsville Sacred Heart Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** Days West Virginia 1 □ M 2 🛛 F Oct. 10, 1916 Director 234-10-6301 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examiner is ust be notified at Director 1 XYes 2 No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 2 and hijury or other traumatic event, the Medical Expression to once. USA 20720 11900 Backus Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: USA Specify. þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vena Ferguson Mason Miller ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11900 Backus Drive Bowie, MD 20720 Roger K. Layman/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/31/2008 | Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 alla 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mknown 3heime disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed and physician ar s the burial-t Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Month Year 5 Other (specify) P.0. s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has t , page 2 s autopsy performs or Attending Physician: The certificate 1 ☐Yes 2 ☐ No 1 ∐ Yes director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 27. Mann eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 atural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number liswalle 30. Name and address of person who completed cluse of death (Item 23a) (Type, Print) CHOWDHURY, MD; 15216 DINO DRIVE; AURTONSVILLE, MD 20866 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Isaiah Leneau /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sinai Hospital of Baltimore Baltemore city If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10 30 192 **Funeral** 250.28.6611 Min. Months Days Hours 82 Director PIPSI Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evanting must be notified at Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3500 Edgewood Koad 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify. þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) S Steel Worker 12th Grade Maryland 18. Mother's Name (First, Middle, Maiden Surname) KNOCON 17. Father's Name First, Middle, Last) Leneau Martha Dwyer 2 Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dr. Marvin P. Leneau/Son 4712 New Town Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ginam positive Cocci /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 □Yes 25. Was case referred to medical examiner? Be Hospital: Certification: To 1 Yes 2√ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 3 ☐ Suicide 6 ☐ Could not be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Boulevard Owings Mills MID 20c. Location - City or Town, State 08/04/08 | Owings Mills, MO 22. Name and Address of Facility Vaughn C. Green turval Sovices 8728 Liberty Road Randallstown MD 21133 Approximate Interval Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐Yes 2 ☑No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 102 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number RES - 000 TULY 28,2008 Hospital BALTIMORE Of

Day

25

Vear

2005

14. Race - American Indian, Black, White, etc.

Specify:

16b. Kind of Business/Industry

Bethlehem

Black

4c. County of Death

20. in M

Birthplace (State or Foreign Country)

SC

10d. Inside City Limits

1 XYes 2 No

State

within 24 hours a

Medical

DHMH 17 Rev 1/2001

Registrar

SINAI

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

3 Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROKKAM

determined

oldcam

JUL 3 1

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

ARUNA,

31. Date filed (Month, Day, Year)

29a. Certifier

Dhysis		1 - State Amend Item 24a 1. Decedent's Name (First, Middle, Last)		OCITATION	10 07 2		2. Date of Dea		10	3. Time of De
Physic		TONI	MITCHE	ELL			Month 07		Year	1:25 P
/Medi Exami		4a. Facility Name (If not institution, give stree	et and number)	4b. C		Location of De		4c. County of	t Death	
		LAYHILL REHAB	CENTER			SPRI				MERY
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. last	Yrs. Month		If Under 24 H Hours M		y, Year)	9. Birthpla Counti	ace (State or F Ty) 1
il ector	1	Usual Residence of Decedent	00				Jan 21,	1740		
a how		10a. State 10b. County		Town or Location					10	d. Inside City
- Ballo	Director	MD Montgomery	51	llver Spr				40-022		
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ms 23	Funeral	11 Marital Status UNK 12	Was Decedent Ever in U.S.	13. Was De			(Specify Yes or No erto Rican, etc.)		- America	
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E E	d by	3 Widowed 4 Divorced	Year or Dates:	1 1016	2X No	Зреспу.			blac	
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Medical		resulting in death)	Due to (or as a consequer							
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leath. tor: After this certificete hes the funeral director, page 2	Certification:	4 Homicide determined	building, etc. (Specily) an: To the best of my knowle	adye death occur	ed at the time	e date and pla	ice and due to the	cause(s) and mar	nner as sta	the causa(s)
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DHMH 17 Rev 1/2001

Registrar

			Certificate of Maryland / Department of Health and M	Reg. No.	8 24632
			Decedent's Name (First, Middle, Last)	2. Dete of Deeth	3. Time of Death
1	Physicia /Medic		Hilda McQuay	July 28, 201	08 7:02 PM
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	Francis		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9.	ATI MORE Birthplece (State or Foreign
	Funeral Director		218-12-2886 10 M 2 F 83 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Year)	Birthplece (State or Foreign Country)
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E	nd 2 selfth er 27 is		Mr John Smothers 2404 Callow Av	o. Balto Md	21217
J.e,	of Heelth Item 27 r other t		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory of other place)	Date 20c. Location - City	, , ,
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A. Carlot			23a. Pert1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arrest,	Approximate Interval Between Onset and Death
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000		piete		performed?	available prior to completion of cause of deeth?
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	6	}	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)	(1)	2/228
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a,	Stat Registra		31. Date filed (Month, Day, Year) 2008 22. Registrar's Signature)	

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ian Canillo Martir	1- For State of Maryland / Department of Health and Mental Hyglene Certificate of Death Reg. No. 2008 24	63
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year Od40 bro	
ledical Examine	Juan Camilo Martinez July 26, 2008 0140 flis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
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Funeral Director	5. Social Security Number None 6. Sex 7. Age (In yrs. last birthday) 1	
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e, MD and 2 sho Health and item 27 is	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	\dashv
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: All Souls Crematory 7-31-08 East Elmhurst, NY	
Saltil ermit. Pepartm mports	21. Alignature of Funeral Service Correct 22. Name and Address of Facility Leo F. Kearns Funeral Homes, Inc.	
Physician	23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate In	
/Medical xaminer	failure. List only one cause on each line. Between Onst Death A Head Injuries	et and
xammer	or condition resulting in death) Due to (or as a consequence of):	
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
led Insit	Consider the controlling cause (Disease or highly that hillated events resulting in death) Last Due to (or as a consequence of):	
760, cate be executed physician and he burial - transit		
60, ate be ex hysician	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
687(ertifica	23b. Was decedent pregnant in the past 12 months? 25b. If yes, obtained it pregnancy 1	ar
). Box 68760, the death certificate be executed to the attending physician and reched for use as the burial - transfer of the control of the	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	
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Division of Vital Records, and or Attending Physician: The law requirers after death. al Director: After this certificate has been seen in by the thoreal director, page 2 should then by the funeral director, page 2 should then by the funeral director.		
/isior r Attend ter death irector: n by the	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number or Town, State)	er, City
Division or Spiral or Attending tours after death.	4 Homicide determined (Specify) Local Street Spencerville Road at Kruhm Road, Burtonsville, N	ND
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transition of the formation of the form	1 29a Centiller . Le va . Le v	
To with To com	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	Waryanis The Will O.C.M.E. July 27, 2008	
5	30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registra	JUL 3 1 2008 Booms St. Aparts	

			For State	State	of Marylar	-			Mental Hy	20	100	21 (21
			Registrar 1. Decedent's Name (First, Middl	In I cot)		Cei	rtificate of	Death	2. Date of De	Reg. No. 🔼 👢	108	24034 3. Time of Death
	Physicia	an	Evelyn	le, Last)	2	Ac acc			Month 7	Day 2	Year	19 15 AM
	/Medic Examin	in a	4a. Facility Name (If not institutio.	n, give street and n		Magee	4b. City, Town,	or Location of Dea		4c. County	of Death	12.631
,		e i	St. Mary's Hos		,		Leonai	rdtown		St. Ma	arv's	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)		r If Under 24 Hr		th I		ace (State or Foreign
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	deat	Funeral	11. Marital Status		cedent Ever in l		Was Decedent of	Hispanic Origin? ((Specify Yes or No erto Rican, etc.)		ce - America ck, White, e	
9	or It		1 ☐ Never Married 2 Mar	nied 1 ∏ Yes If Yes. 0	; 2∭XNo Bive	i	11√2 Yes 2□ N		, , , , , , , , , , , , , , , , , , , ,	Specifi		
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7	with pene. r thar the M	Completed	Elementary/Secondary (0-12)	College 2	(1-4or 5+)	Resta	urant Ma	anager		Restau	ırant	
2	uld be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show atic event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle,	Last)					ame (First, Middle,			
<u></u>	uld be Vents Irked Itic ev	To E	Juan Santos Pl	Laza				Evange1	ista Ser	rano		
<u>a</u>	bus E M	' [19a. Informant's Name/Relations	ship (Type. Print)		19b. Maili	ng Address (Stre	et and Number or I	Rural Route Numb	er, City or Town,	State, Zip	Code)
.` ``	and lealth m 27 her tr		Kenneth D. Mag	gee (Hus	band)				Unit B-2			
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ם	permit. Pages 1 and 2 Department of Health s Important: If Item 27 Is any Injury or other tra		21. Signature of Funeral Service	Littage	en			ress of Facility neral Hom	e Lorain,	он 440	5.5	
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications tha t only one cause of	caused the dea		ter the mode of d	ying, such as cardi	iac or respiratory a	rrest,		Approximate Interval Between
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א מ	ath ce	ian/	23b. Was decedent pregnant in the past 12 morals?	1 ☐ Live	outcome pf pregre birth 2 Fe	tal death 3[_Ectopic pregnar				ate of deliver	ry Day Year
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 █ No 9 ☐ Unknown	4∐Pre 9□Uni	gnant at time of mown	death 5	Other (specify)			200		,
ŗ.	that t ed by detac		Part II. Other significant condit	igns contributing to	eath but not re	fulting in the u	inderlying cause	given in Part I.	23e. Did 1	obacco use con	tribute to the	e cause of death?
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	hysic his ce I direc	To E	examiner? 1 Yes 2 No	Hospital: 1 [Inpatient 2] ER/Outpatie	nt 3□ DOA	Other: 4 \(\sum \) Nursing	Home 5□Resi	dence 6 □Otl	her (Specify)
-	Ing P		27. Manner of Death 1 ☑ Natural 5 ☐ Pendi		te of Injury onth, Day Year)	28b. Time of Injury	N N	ijury at Vork?	28d. Describe	how injury occur	rred	
200	tendleath.	cati	2 Accident invest 3 Suicide 6 Could	igation				☐ Yes 2☐ No	00/ 1 - 1	21 11		
2	al or A	Certification:	4 ☐ Homicide determ	mined 200. Pia	Iding, etc. (Spec	cify)	reet, factory, offic	ce	City or To	Street and Numi wn, State)	ber or Hurai	Houte Number,
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical (ing Physician: To t I Examiner: On the and m								
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(in T		30. Name and address of passor	on completed to	use of death (Ite	em 23a) (Type	Print) F	0 24	Conmo	Kwu.	1.	1) 20650
	Sta Registr		31. Date filed (Month, Day, Year JUL 3 1		Registrar's Sign	nature	the second		4.5	, /		,
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Amend 20c, perFH, G881 7/31/08 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Helen Marschat 7-29-2008 9:57P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 0akcrest Parkville Balto. 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2QF Months Days Hours Min. 217-22-0137 102 11-5-1905 Director Md. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 ☐Yes X☐ No ural", or items 23a or 28a-f st Examiner must be notified Director Balto. Md. Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 USA 8832 Walther Blvd Funeral Rm 123 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3X Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event once. other traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Hlavin မ John Cihlar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bertha Huettner 2 Bunker Ct. Ocean Pines, Md. 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State 8-4-2008 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) P.0. cate has been signed by the a page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. à 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate has Attending Physician; funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Iniury 5 Pending investigation 1 ☐ Yes 2 ☐ No al or Attendl s after death. death. 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of cepifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walther Blud Parkylle MB 21234 Hosha 31. Date filed (Month, Day, Year) State 0

Registrar

MSCHE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiere 0 0 8 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Day Month enni : 45A 00 uli 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street and number) Center Wina Baltimore If Under 1 Year | If Under 24 Hrs.
Wonths Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 25, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 □ M 2X F Months 1919 Washington Aug. 139-18-2956 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 1 No Maryland Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 3700 College Avenue #206 21043 USA 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates:1940-45 Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Special Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mark Mattison McChesmay Elizabeth Savage 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8401 West Grove Road; Ellicott City, MD 21043 Donna A. Mennitto Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ic Crematory 7/30/2008 Glen Bu 22. Name and Address of Facility Sterling Ashton Funeral Home of Catonsville, Inc 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Ashton Schwah Atlantic Crematory 21. Signature of Fugeral Service Licensee M0/490 1630 Edmondson Avenue; Catonsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) days Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner burial-transit

Physician

/Medical

Examiner

Funeral

Director

Items 23a or 28a-f show

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the Medical Examiner must be notified at

Director

Funeral

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Completed

death with the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumation according to the process.

Baltimore, Maryland 21215-0036

Examiner attending physicien and for use as the burial-tran Physician/Medical þ Completed tuneral director, Be

Division of Vital Records, P.O. Box 68760,

al or Attending Physician: atter death. I Director: Atter this certitica

hin 24 hours a Hospital

the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No

examiner? 1 ☐ Yes 2 No

27. Manner of Death Natural 2 Accident 5 Pending

investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

1 🗌 Yes

28d. Describe how injury occurred 2 No

29a. Certifier (Check only one)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

3 Suicide

4 Homicide

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) 3520 MD

31. Date filed (Month.

32. Registrar's Signature

State Registrar

Director

Completed by Funeral

Be

2

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

Physician

State Registrar			Ce	ertifica	ate of	Death				21	<u> </u>	2463
Decedent's Name (First, Middle, La.	st) D	U	CA	111	VI I	١		2. Date of De Month	Day		Year	3. Time of Death
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State Registrar DHMH 17 Rev 1/2001

2008

31. Date filed (Month, Day, Year)

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ORIGINAL

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REISTERSTOWN MD

July 29. 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 27, Day 2008 Physician Gary A. Morgereth 10:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2807 Virginia Avenue Baltimore If Under 1 Year | If Under 24 Hrs. Date of Birth Month, Day, July 5, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Mary Land 218-48-0478 61 Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at Director 1 ☐ Yes 2 📆 No Baltimore Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2807 Virginia Avenue 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married Married 1 □Yes 2 XNo White Specify þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paint Manufacturer Manager Father's Name (First, Middle, Last)
William Morgereth 18. Mother's Name (First, Middle, Majden Surname)
Loretta Getek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2807 Virginia Avenue, Baltimore, MD 21227 Cecelia Morgereth - Wife 20b. Place of Disposition (Name of West (Arunder) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 X Cremation 3 ☐ Removal from State □ Dopation 5 □ Other (Specify) 7-29-2008 Odenton, Maryland Crematory 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Date to (or as a consequence of Examiner if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 DUnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 1∐Yes 2∭j 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, attending p P.O. signed i Division of Vital Records, cate has l , page 2 s certificate

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and s the burial-trans After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

29b. Signature and title of certifie

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person ed cause of death (Item 23a) (Type, Print)

134 Pasadena MD 21122

State Registrar

Medical

29a. Certifier

(Check only

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Mary Madeline Milando 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SAUT mo (LE If Under 1 Year | If Under N/A HOSO ME AGNO 8. Date of Birth May 21, Year) May 21, 1926 5. Social Security Number Birthplace (State or Foreign Country) ge (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Davs Hours Min. 82 213-20-3454 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Newton Extrainment he notified at 1 ☐ Yes 2 🙀 No Director Maryland Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3300 Benson Ave. 21227 Apt. 204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ♣ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George A. Otter Margaret George 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Toomey, daughter 1016 Donington Cir Towson, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Cemetery 07-31-08 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ² Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. A Arbutus, MD. 21227 Approximate Interval Between Onset and Death 23a. Peri 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 E No 2 No 1 ☐ Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide after Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 10040035 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Registrar

JAVED

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DEPARAMENT OF SU FWERZ Registrar's Signature

To your off

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEN THE 10b per H. (881, 7/31/08 WS)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician MCDANIELS ARSHA JULY 26 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY HOSPITAL OHNS HOPKINS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 5 212-62-5424 3 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 Ves 2 No Baltimore MD Director 10e. Street and Number 10g. Citizen of What Country? SIS N 2123 chester Completed by Funeral Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No if Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Office Manager 4yrs Development Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna McDaniel James ပ 19b. Mailing Address Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) McDaniels-Cisse 7 N. Boardway Baltimore, MD 21231 Jan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Dedrial 2 ☐ Cremation 3 ☐Removal from State 8.1.2008 Baltimore MD ing Memorial 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility Vaugnin C. Greene Fureral Services 21. Signature of Funeral Service Licensee Sheano 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York Ad Baltimore, Mi) 21212 Immediate Cause (Final disease or condition resulting in death) **Physician** Right heart reeks /Medical Due to lor as a consequence of): Examiner ulmonary Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner requires that the death certificate be executed Sarcoidosi the burial-tran Due to (or as a consequence of): or Vital Records, P.O. Box 68760, use as IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a be detached f 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed? 2 No 2 No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. Director: A 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26,2008 RES-000 MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St. Baltimore MD, 21287 ANN YATES ENNIFER MD 32. Registrar's Signature 3 1 2008 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician PM 17:29 TUL 25 2008 GLORIA MCKELVIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 217-70-0182 1 M 2 M Director Usual Residence of Dece 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Tes 2 □ No Director timore 10g. Citizen of What Country? 10f. Zip-Code death with Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√ If Yes, Give Year or Dates: Maryland 21215-0036 2 No 1 Tyes ٥ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r ife. DO NOT use retired) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 8. Mother's N me (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be ... Department of Health and Mental ... Important: If item 27 is ... any injury or other. Be State, Zip Code 21206 19a. Informant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, bara . Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HOPENSION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami The law requires that the death certificate be executed physician and as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the att 2 No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, PULMONARY HYPERTENSION 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DISORPER MIXED CONNECTIVE TISS VE autopsy performed? has 2 No 1 Tyes 2 No certificate 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Hospital: 1 Sinpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) မ this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: I or Attending F after death. 5 Pending investigation 1 Natural after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 - Homicide City or Town, State) 24 hours Funeral Hospita 29a. Certifier (check only 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the To the To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

37

State Registrar 31. Date

FOWIN OSTRIA, MO, PHD

filed (Month, Day, Year)

JUL 3 1 2008

32. Registrar's Signature

30. Napre and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

JULY 25, 2008

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			State of Maryl		artment of H				
, •	Physici		Registrar 1. Decedent's Name (First, Middle, Last) Nancy M.		iller	Deam	2. Date of Dea Month July	th Day Year 2008	3. Time of Peatif 6:59 A _M
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Death	July	4c. County of Deat	h
			1926 Armco Way		Dunda			Baltimo	
See .	Funeral Director		236-64-4874 ^{1□M} 2€ 67	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 1	, Year) Co	nplace (State or Foreign untry) st Virginia
	and www.t		Usual Residence of Decedent 10a. State 10b. County 10c.	. City, Town or Lo	ocation				10d. Inside City Limits
	e Mary Ba-f sho	Funeral Director	Maryland Baltimore		Dundal	k			1 □ Yes 21 No
	with th	Dire	10e. Street and Number		10f. Zip Code	01000	1	10g. Citizen of What Co	
	ns 23	eral	1926 Armco Way 11. Marital Status 12. Was Decedent Ever i	n U.S. 13.	Was Decedent of H	21222 lispanic Origin? (Sp	ecify Yes or No-	United Sta	
336	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Ex-miner must be notified at	by Fun	Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an', Mexican', Puèrto Specify:	Rićan, etc.)	Black, White	White
2-0	72 hou		15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation during most of work	cina I	16b. Kind of Business/	
21215-0036	s 1 and 2 should be filed within 72 hr if Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, the Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12 Years		kind of work done of DO NOT use retired memaker	i)	, in ig	Own Home	2
	e filectal Hyg	BeC	17. Father's Name (First, Middle, Last)					Maiden Surname)	
yla	ould by Ment larked	5	Carl McIntire 19a Informant's Name/Relationship (Type Print) Husban	A			le Cook		
	1 and 2 sh Health and tem 27 is rr		Mr. Charles G. Miller, Sr.	100. 1110.111	-			r, City or Town, State, 2 ryland 2122	
Baltimore,			1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State	-	matory or other plac	ce)	Date	20c. Location - City or	
Him	permit. Page Department of Important: If any injury or once.	l	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		Cemeter	_		Baltimore,	Maryland
Ba	permii Depar Impor any ir	(5)	Healte Caen			-		Maryland 2	· ·
8760,	Physician and /Medical Examiner sthe pnial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition or as	Sequence of)	FAIL	eRE Lue Luy	Disea	re .	Approximate Interval Between Onset and Death
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome pf pro 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic pregnancy	у		23d. Date of dei Month	ivery Day Year
Δ.	quires that an signed by ald be deta	þ	Part II. Other significant conditions contributing to death but not CHLO Nic Myelvi 1	resulting in the u	, , ,	en in Part I.	23e. Did to	obacco use contribute to 'es 2 □ No 3 □ Pr	
Records,	The law requirate has been sage 2 should	Completed	J				24a. Was a autop perfor 1 Yes	sy prior to death?	utopsy findings available completion of cause of
Vital	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?			26. Place of Dea			
or	ding Physician: The	မ	1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatier		4 Li Nui sing n		ence 6 Other (Spe	cify)
on	nding th. : After	tion	Natural 5 ☐ Pending (Month, Day Year 2 ☐ Accident investigation	(r) Injury	Wor	k? Yes 2∐No	zba. Describe n	ow injury occurred	
Division	l or Attending I after death. Director: After I in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - A building, etc. (Sp.	At home, farm, str necify)	reet, factory, office		28f. Location (S City or Tow	Street and Number or Re rn, State)	ural Route Number,
\ \ \	To the Hospital or Attending Physician: within 24 hours after death. Jo the Funeral Director: After this certific completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner and manner stated.						
ソ	2 × × ×	Me	29b. Signature and title of certifier		29c. Licens	se number	4	29d. Date signed (Mont	
	80		MT timp		Doe	21859		5- 29.0	8
	0		30. Name and address of person who completed cause of death TARING 23	Item 23a) (Type,	ac Allan	Betw	0 2/2	.24	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's S JUL 3 1 2008	ignature	Sault)				ri .

DHMH 17 Rev 1/2001

			For State of Ma	ryland / Depa			ental Hygie		01610
			Registrar	Cer	rtificate of L	Jeath	Reg	. No. 2008	
	Physicia	an	1. Decedent's Name (First, Middle, Last)				Month	Day Year	3. Time of Death
· manage	/Medic		HELEN MAXINE McCOMBS 4a. Facility Name (If not institution, give street and number)	1	4b. City. Town, or	Location of Death	JULY 29	2008 4c. County of Death	8:30 A ^M
, j	Examin	er	502 Magnolia Road		Joppa			Harford	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		place (State or Foreign
	Director		410-30-5340 1□M 2∏F	83 Yrs.	Months Days	Tiodis Willi.	Feb. 26,	1925 No.	rth Carolina
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho	to	Maryland Harford	Joppa					1 □ Yes 2 🙀 No
	r 28a	Director	10e. Street and Number	оорра	10f. Zip Code		10g	g. Citizen of What Cou	intry?
	th with		502 Magnolia Road		21085	5		USA	_
98	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modral Eventine must be notified at or other traumatic event, the Modral Eventine must be notified at	y Funeral	11. Marital Status 12. Was Decedent E Armed Forces? 1 Never Married 2 Married 1 1 Yes, Give	0	Was Decedent of H If Yes, specify Cuba 1 □Yes 27 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	city Yes or No- Rican, etc.)	14. Race - Amer Black, White, Specify:	etc.
215-0036	hours tural"	ed by	3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education	16a Dece	dent's Heual Occum	ation	16	ib. Kind of Business/li	nite
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212	filed within Hygiene. ther than "int, the Wo	No.	12	· I	memaker			Own Home	
nd	e filed tal Hygid I other	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			
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Maryland	12 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Type. Print) Brenda A. Commer / Daughte					City or Town, State, Zing $ ext{ryland}$, $ ext{21}$	
	1 and 2 Health tem 27 l		20a. Method of Disposition	20b. Place of Dispo				c. Location - City or T	
altimore,	permit. Pages 1 a Department of He Important: If item any Injury or othe once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			į	0.00	M	
a∰	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	Hilltop	Service C 2. Name and Addre	o of Contline		owson, Mar neral Home	-4-
ä	an De d		Stoppe a Needs		1317 Col				yland 21009
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ent	ter the mode of dyir	g, such as cardiac	or respiratory arres	it,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	de Des	mention				Onset and Death
	/Medical Examiner		resulting in death) a. Due to (or as a	consequence of):					
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	consequence of):					
	outed d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
oʻ	e exec an an irial-tr	Exa	resulting in death) Last Due to (or as a	consequence of):					
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9 ×	certific ding p	/Mec	IF FEMALE: 23c. If yes, outcome of	of prognancy					-
O. Box	or Attending Physician: The law requires that the death certif after death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1	2 ☐ Fetal death 3 ☐	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	у		23d. Date of deli Month	very Day Year
<u>a.</u>	that the ed by detacl		Part II. Other significant conditions contributing to death bu	t not resulting in the u	inderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
of Vital Records,	juires tha n signed l	d by					1 □ Yes	2 No 3 Pr	obably 4 Unknown
S	law requir as been s 2 should	Completed					24a. Was an	24b. Were au	topsy findings available
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ita	sician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?			26. Place of Deat			
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Ę.	ding P. h. After funera		27. Manner of Death 28a. Date of Injur (Month, Day	y 28b. Time o (<i>Year)</i> Injury	Wor		28d. Describe how	injury occurred	
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ō	al or Att	Certification:	4 Homicide determined building, etc	. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town,	State)	,
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4	To the within To the Complete	Me	29b. Signature and title of certifier	A.A	29c. Licens	e number	29	d. Date signed (Monti	n, Day, Year)
			Glevelia Krehr	- 170	D.	500 41	/	07.64	1008
_			30. Name and address of person who completed cause of de	eath (Item 23a) (Type,	Print) # 10	12; &	logener	od 17	D21040
	Sta		31. Date filed (Month, Day, Year) 32. Registra	r's Signature	and .		U		
	Registr	ar	COLUT TOOO TOO	I Si MIN					

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene rgiene Reg. No. 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 **Physician** 21 2008 1:30a. M Rosina Norman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rose Marie Manor Assited Living Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Year) 22 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Funeral Months Days Hours Min. 1 M XXF 08 06 MD Director 85 216-18-7506 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Markel Expriser; ust be nutified in once. Director YYes 2 □ No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. 3305 Penfold Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ 3 ☐ Widowed 4 ☑ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Toll Both Collector New York State 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marion Nunnally ပ္ Arthur Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 Grafton Brown-Brother 3305 Penfold Drive, Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 7/28/08 Arbutus, Md 22. Name and Address of Facility Funeral Service Licensee 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine y physician and is the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a d be detached for P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ icate has been sig ; page 2 should b 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? The certificate 2 🗆 No 1 □Yes 1 Tyes Physician; director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42836 072208 30. Name and address of person who completed cause of deato (Item 23a) (Type, Print) 29, SOUTH PACA STREET, BALTIMORE MD 21201 KHANNA, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 24645

	1- For State Registrar		rtificate of	Death			eg. No.		, , , , , , , , , , , , , , , , , , , ,
Physician/ ledical Examine	Decedent's Name (First, Middle Renneth Edw.	ard Nyack				2. Date of Dea Month July 27, 2	Day \ 008	′ear	3. Time of Death 2117 hrs
pt M.	4a. Facility Name (if not institution Maryland General Hos			4b. City, Town, or Baltimore	Location of Dea	ath	4c. Coun	ty of Death	
Funeral		6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Yea	r If Under 24	Irs. 8. Date of Bi	rth(MM/DD/YY	YY) 9. Bir	thplace (State or
Director	219-96-5000	1X M 2 F	· 53 Yrs	Months Day	s Hours M	March	4, 195	5 Foreig	puntry) Trinidad
	Usual Residence of Decedent	40.00	T						10d. Inside City Limits
ow any	10a. State 10b. County		, Town or Locat Baltim						1 X Yes 2 No
Maryfand 28a-f show Latonce.	Maryland N/A	A	Daltill	10f. Zip Code			10g. Citizen of	What Cou	intry?
th the Maryland 23a or 28a-f sho notified at once	11 West 20th St	reet Apt. 130		212	18		US	A	
leath with ritems 23 must be no	11. Marital Status	12. Was Decedent Ever in t		as Decedent of His				ace - Amei hite, etc.	rican Indian, Black,
or ite		arried 1 Yes 2 X No orced If Yes, Give Year		Yes 2 X No		,	Speci	oc Wes	t Indian
urs afte	45 Decedent's Education (Spec	or Dates: cify only highest grade completed)	16a. Deceder	nt's Usual Occupa	ition (Give kind		16b. Kind of		
72 hour natu	Elementary/Secondary (0-12)	College (1-4 or 5+)		nost of working life		retired)			
5-0036 led within 7 Hygiene. other than the Medica	A Total Alexandria	2	Automo	otive Med		me (First, Middle,		age	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medical	3 17. Father's Name (First, Middle, Shepherd Nya	· ·			Victo				}
Me Me s	19a. Informant's Name/Relations	hip (Type, Print)		g Address (Stre	et and Number	or Rural Route Nu	mber, City or 1		
- P = E = E	Joan Madden Nya			est 20th		t Apt.13			, MD 21218
Baltimore, permit Pages I an Department of He Important: If ite		3 Removal from State	crematory or o	ther place)	· 1			•	1
Baltimo permit. Page Department Important: injury or out	4 Donation 5 Other Sp. 21. Signature of Funeral Service	700117		ematory Name and Addres		7/30/08			, Maryland
Ba Deprim Imp	Thomas Gregor	Thomas Tru	2	remation 99 Frede	Societ rick Ro	y Of Mar ad Balti	more,	Maryl	and 21228
Physician	23a. Part I. Enter the disease, or failure. List only one cause	complications that caused the dea	h. Do not enter	the mode of dying	, such as cardia	or respiratory a	rest, shock, or	heart	Approximate Interval Between Onset and
/Medical -xaminer	Immediate Cause (Final disease or condition resulting in death)	a. Hemopericardium Due to (or as a consequence	of):						Death
	Sequentially list conditions,	b. Ruptured Aortic Disse							
	if any, leading to immediate cause. Enter Onderlying Cause	Due to (or as a consequence c.	of):						
	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):						
		d							-
8760, tificate be execut on physician and as the burial - trail	IF FEMALE:	23c. If yes, outcome of pre	egnancy				23d. Dat	e of delive	ry
687 ertifica ding p			2 F	etal death 3	Ectopic pre	gnancy	Mont	h	Day Year
by the attendial	1 Yes 2 No 9 Uni	known g Unknown	5 C	other (Specify)					
P.O. Box 68' ss that the death certification greed by the attending to detached for use as:		tions contributing to death but no	resulting in the	underlying cause	given in Part I.				o the cause of death?
S, P.O. Lires that the n signed by the detached by the detached by the p. D.	Hypertensive atheros	sclerotic cardiovascular dis	ease			1 Y	es 2 No		obably 4 Unknown autopsy findings available
cords, law requir has been s						aut	opsy formed?		completion of cause of
Rec The I	Typertensive dance			00.51	(5) 11 (0)	1 ✔ Yes		1 🗸	Yes 2 No
of Vital Rec g Physician: The fler this certificate neral director, page		Mary alberta	✓ ER/Outpatier		Other	ursing Home 5	Residence	6 Oth	er:
Tale P	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time of		ury at Work?		e how injury o	curred	
ion tendir leath. tor: A	1 ✓ Natural 5 Pend 2 Accident Inve			1	Yes 2 No				
Division rs after death. rat Director: /	3 Suicide 6 Cou	Id not be 28e. Place of Injury - At	home, farm, str	eet, factory, office	building, etc.	28f. Location or Town		umber or f	Rural Route Number, City
		hysician: To the best of my knowle	edge death occ	urred at the time.	date and place.	and due to the ca	use(s) and ma	nner as st	ated.
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filted in by the filted	(Check only one) 2 Medical Exa	aminer: On the basis of examination and manner stated.	and/or investig	ation, in my opinio	on, death occurr	ed at the time, da	te and place, a	nd due to	the cause(s)
F. 18 7 8	29b. Signature and title of certific				nse number				fonth, Day, Year)
	Allen Bra			0.0	:.M.E. 		July 28	2008	
1	30. Na e and address of person Melissa Brassell, MD	who completed cause of death (Ite Assistant Medical Exan		Penn Street,	Baltimore. N	MD 21201			10
Stat									
Registra	1111 12 1	2008 32 registrar's Sign	The same of the same						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of F rtificate of I	lealth and N <i>Death</i>	lental Hyg	jiene eg No 20 (18 24646
	Physici	A CIP	1. Decedent's Name (First, Middle,	Last)	•			2. Date of Deat Month	th	3. Time of Death
-	/Medic	al	Dorol		Partee			7	27 0	8 6.00 AM
7	Examin	er	4a. Facility Name (If not institution, Season's Hosp	1			r Location of Death	n	4c. County of	timore
	Funeral		-	6. Sex 7. Age	e (In yrs, last birthday)	If Under 1 Year Months Days				. Birthplace (State or Foreign Country)
	Director		246-22-8161 Usual Residence of Decedent	1□M 2√ F	82 Yrs.	Worth Days		05 09	26	NC
	yland Mow		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Sa-fsh	ctor	MD N	A	Bal	timore				1 XYes 2 □ No
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	•
	ns 23	eral	2902 Woodland	AVE	Ever in U.S. 13. V		1215 lispanic Origin? (Sp	ecify Yes or No-	U.S	• A • American Indian.
ထွ	72 hours after death with the Maryland natural", or Items 23a or 28a-f show iteal Exeminational benefits dat	Fur	1 ☐ Never Married 2 ☐ Marrie	Armed Forces?	No	lf Yes, specify Cuba 1 □Yes 2 ∑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black,	White, etc.
5-0036	ural",	d by	Widowed 4 Divorced	Year or Dates:		••	. ,			Black
15-	in 72 in "nat	plete	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina most of work	ing	16b. Kind of Busin	ness/industry
2121	ed with /giene er tha	Completed	12th grade	College (1-4or 5)+) P	acker		V	Vesting	nouse Co.
and	be file	Be	17. Father's Name (First, Middle, L	ast)			18. Mother's Name	e (First, Middle, I	Maiden Surname)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Event in a matter by notified at once.	은	Jacob Pass 19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mailir		Fannie and Number or Rui			ate. Zio Code)
M.	and 2 salth a 27 is er trau		JoAnn Partee-	Daughter			nd Ave,			
Baltimore,	ges 1 at 1 of He If item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		20b. Place of Dispo cemetery, cren				20c. Location - Ci	
ţ	it. Pag rtmen rtant: njury		4 Donation 5 □ Other (Sp.	ecify)	Druid		8/1	/08 E	Pikesvi	lle, Md
Ba	permi Depar Impo any Ir		21. Signature of Funeral Service L	censee	, Ma	2. Name and Addre	West	D-1+4-	7.6 A	a 21215
			23a. Part 1. Enter the disease, or o shock, or heart failure. List o	omplications that caused	the death. Do not ent		sh Ave, ng, such as cardiac			d 21215 Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	bov	vel obstr	action				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of:					
B.	scuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с						
68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	al Ex	resulting in death) Last	Due to (or as	a consequence of):					
289	ificate g phys is the	edical		d						
Вох	eath certir attending for use a	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		∃Ectopic pregnanc	44		23d. Date	
O. B	ie dea the at hed foi	Physician/M	in the past 12 months? 1 □ Yes 2 ② No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown		Other (specify)			Monti	n Day Year
Я.	ires that the de signed by the be detached f		Part II. Other significant condition	is contributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
rds	quires en sigr uld be	ed by	shote					1 □ Y€	es 2□No 3	□ Probably 4 Unknown
eco	faw requir as been s 2 should	Completed	Curona	yartery dise	use			24a. Was a	ın 24b. We	ere autopsy findings available
a B	iclan: The lav certificate has ector, page 2	Con	hyper	fen slon				perfori 1 □Yes		or to completion of cause of ath? Yes 2 No
Vita	siclan certif irector	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		Oth	26. Place of Deat			(Specify) hospice
Division of Vital Records,	ding Physiclan: n. After this certific funeral director,	n: To	27. Manner of Death	28a. Date of Inju	ent 2 ER/Outpatier Iry 28b. Time of Injury	IL 3 LI DOA	4 LI Nursing Ho	ome 5 Reside	ence 6 Other ow injury occurred	(Specify) 1103 11CC
sior	Attendin ar death. ector: Af by the fur	catio	1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	ition	y, real/		Yes 2 □ No			
Öİ	or Att after d Direct in by	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Si City or Town		or Rural Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying	Physician: To the best	of my knowledge, deat	h occurred at the ti	me, date and place,	, and due to the c	cause(s) and man	ner as stated.
	the Ho in 24 I the Fu	Medical	one)	xaminer: On the basis o and manner sta	of examination and/or in ated.	vestigation, in my o	opinion, death occur	red at the time, d	fate and place, an	d due to the cause(s)
	or ¥i¥	Σ	29b. Signature and title of certifie			29c. Licens		2	29d. Date signed (Month, Day, Year)
	_		30. Name and address of person w	the completed cause of d	leath (Item 23a) (Tuna		60680		T]	01/00
_	り		30. Name and address of person we EUNSE M 31. Date filed (Month, Day, Year)	LITELIUN	7 nu Mains	+ Reister	stunn, M.	U 1136		
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	1 2008 32. Registra	ar's Signature	carti				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Month **Physician** Prescott /Medical Donnie 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Inder 1 Year If Under 24 Hrs. Samaritan If Under 1 Year 8. Date of Birth (Month, Day, Year)
03 26 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min. **№** M 2□ F Director 54 sc214-62-5968 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the World Event is a count be notified at 1 Yes 2 □ No Director Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21239 U.S.A. 4553 Marble Hall Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Black ð 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Contractor llth grade na Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Harry Willie Prescott Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3000 Towanda Ave Apt 407, Baltimore, Md 21215 Ruth Prescott-Mother more, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park7/28/08 Woodlawn, Md Baltii 21. Signature of Funeral Service Licensee Name and Address of Facility. 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myo cardial Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine and that initiated events resulting in death) Last ing physician ar e as the burial-t Due to (or as a consequence of): 68760. Physician/Medical attending p for use as Box (IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month signed by the a d be detached fo 5 Other (specify) Ö 1 □Yes 2 □No 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. ģ 1 Yes 2 No 3 Probably 4 Onknown Completed pluods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has I autopsy performed? 1 □Yes 2 ₽No 1 ☐ Yes 2 ☐ No e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certifice 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Division (Month, Day, Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fil Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00058570 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Terrance L. Baker MD Good Sanaritan Huspital Baltinore 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 24648 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** July 27, 2008 1:27 AM Mary Ann Platz /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Summerville Assisted Living Facility Prince George's Bowie 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1 □ M 2 🗓 F Months Days Hours Min. 90 217-09-3624 Director 2. 1917 Indiana Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Widgal Examples, is ust be putfied a once. 1 XYes 2 No Funeral Director Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 14997 Health Center Drive 20716 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify \$ 3X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Charles Daniel Einig Isabelle Loretta McComb 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15803 Wayne Avenue Laurel, MD 20707 Austin C. Platz/ Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/1/2008 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee De 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 100 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Cectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 NO 2 **N**0 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 057028 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chopranth, Day, Year)
JUL 3 1 . Leon Ridgely
32. Registrar's Signature Annapolis Avenue #231

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month,

2008

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** POWELL I PANA /Medical Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Year If Under 24 Hrs. Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 83 Months Davs 214 30 Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10d. Inside City Limits 10h County or 28a-f show Injury or other traumatic event, the Wedical Evan increment be notified at SaltiMOVE. 1 Yes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, Its Medical Evant or counce. "natural", or items 23a 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT, use retired) College (1-4or 5+) Elementary/Secondary (0-12) itair dresser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haltimore randel Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greene Funeral Services 21. Signature of Funeral Service License 22. Name and Address of Facility 5151 Baltimore National Hulle Latta, Ma. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician muricardial disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ine Cho To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Man or of Death 28b. Time of 28d. Describe how injury occurred After 1 V Natural 5 Pending investigation neral Director: A filled in by the fu 1 ☐ Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a Certifier 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Division of Vital Records, within 24 hours a To the Funeral C

> d State Registrar

29b. Signature and title of certifier

LEDUUINA

724

maiden Choice

Cane

Scupe 204

and manner stated.

1810

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 1 Ye 2 2008

			For State Registrar		State of Ma	aryland	l / Depa <i>Cer</i>	rtment of	Health and N Death	Mental Hy	/giene Reg. No.	200	3 2465	i (
F	Physicia /Medica	n	1. Decedent's Name (Dennis C	(First, Middle, Last) Charles Re						2. Date of D Month 07-2	eath 5-200)8 Year	3. Time of Death	
	Examine		4a. Facility Name (If n Upper Che			enter		4b. City, Town, Bel A	or Location of Death ${ m ir}$			County of Dea Harfor		
	Funeral Director		5. Social Security Nun 217-38-65	40 ¹ 8	x 7. Ag	e (In yrs. Ia 68	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, D 10-06-	irth lay, Year) -1939	9. Bir <i>C</i>	thplace (State or Forei ountry) MD	gn
	iryland ihow i at	_	Usual Residence of D 10a. State	Decedent 10b. County			Town or Lo						10d. Inside City Limit	
:	death with the Maryland rms 23a or 28a-f show r must be notified at	Funeral Director	MD 10e. Street and Numb	Harfo	ord		Forest	Hill 10f. Zip Code			10g. Citiz	zen of What C		
2	23a c	la L	311 Willr					210				JSA		
3 P/2	ine ite	by Fune	11. Marital Status 1 □ Never Married 3 □ Widowed 4	d 2 🔼 Married	12. Was Decedent Armed Forces? 1 X Yes 2 1 Yes, Give Year or Dates:	Ever in U.S No	1	Vas Decedent of f Yes, specify Cu I□Yes 2XNo	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)		14. Race - Am Black, Whi Specify: W		
2,00	72 hou 'natura dical E	Completed by	(Specify	I5. Decedent's Edu y only highest grad	ication le completed)		16a. Deced	lent's Usual Occu	upation e during most of wor ed)	king	16b. Kii	nd of Business	s/Industry	
Z 22	within iene. r than the Me	omp	Elementary/Second	dary (0-12)	College (1-4or 5	i+)	Labor		<i>60)</i>		Ca1	Lvert D	istillery	
Maryland 2	ild be filed fental Hyg rked othei ilc event, '	To Be C	17. Father's Name (F						18. Mother's Nan Elsie	,	e, Maiden	Surname)		
Mary	and 2 shou alth and M 27 is mai er traumal		19a. Informant's Nam Dorothy R		1.		I	-	et and Number or Ru h Cir. Un					
7/25 altimore	Pages 1 anent of He				Removal from State		.eview	sition (Name of natory or other pl	rk 07-2	9-2008		cation - City o		
Balt	permit. Departr Importa any inji		21. Signature of Fun	eral Service Licens				Name and Add	ress of Facility Sc W. MacPha				me of BelA 21014	ir
	hysician		23a, Part1. Enter the shock, or heart Immediate Cause (Fi disease or condition resulting in death)	failure. List only o inal	ne cause on each li	ne. YPE1	2TEN		ying, such as cardiad	c or respiratory	arrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner	_			b. Due to (or as	YPER	LLIPI	DEMIA						_
2554	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, leading to infinition cause. Enter Underly Cause (Disease or in that initiated events resulting in death) La	ying njury	cDue to (or as									
	icate be physicia s the bur	dical			d									
0. Box 6	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 🗆 Fetal	death 3[□Ectopic pregnar □ Other <i>(specify)</i>			. ;	23d. Date of d Month	elivery Day Year	
SC ds, P.	requires that the een signed by the nould be detache	by	Part II. Other signific	cant conditions co	entributing to death b	out not resu	Iting in the u	nderlying cause o	given in Part I.		tobacco u Yes 2		to the cause of death? Probably 4 Unkno	
)niS Recoi	has has	Completed								24a. Wa au' pe 1□ Yes	topsy rform <u>ed</u> ?	prior to death?	autopsy findings availa o completion of cause o	ble of
ita	sician: Th certificate rector, pag	Be C	25. Was case referre	ed to medical					26. Place of De					
14 [Phys	유	1 ☐ Yes 2 💢 N 27. Manner of Death 1 ☑ Natural	5 Pending	Hospital: 1 ☐ Inpati 28a. Date of Inju (Month, Da	ıry	ER/Outpatie 28b. Time o Injury	f 28c. In		dome 5 ☐ Re 28d. Describ			pecify)	
che Division	or Atten after deatl Director: in by the	Certification:	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	Zoe. Flace of in	jury - At ho tc. <i>(Specif</i> y	me, farm, st	reet, factory, offic			(Street ar own, State		Rural Route Number,	
Re	e Hospital 24 hours a e Funeral letely filled	Medical C	29a. Certifier (Check only one)	1 ⊠ Certifying Phy 2 Medical Exam	/sician: To the best iner: On the basis of and manner st	of examinat	wledge, deat tion and/or ir	h occurred at the evestigation, in m	time, date and plac y opinion, death occ	e, and due to the	ne cause(s ne, date an) and manner d place, and d	as stated. ue to the cause(s)	
	To the Hosi within 24 ho To the Fune completely f	Me	29b. Signature and t	fle of certifier					nse number) /	29d. Da	-	nth, Day, Year)	2

12 State Registrar

person who completed cause of death (Item 23a) (Type, Print)

ahmood, M.D., 2227 Old Emmorton Rd., Sutte 2-12 Bel Air, MD2/05

(Year) 2008 32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

		-	For State Registrar		Stat	e of Ma	aryland	/ Depa	rtment of tificate o	f He	ealth and M eath		giene Reg. No.		8	24651
			1. Decedent's Name	(First, Middle,	Last)							2. Date of Dea		. Va a		3. Time of Death
	Physicia /Medic	_	Glenn E	. Rvan								7-29-20	008	y Yea		8:15P M
-	Examin	_	4a. Facility Name (If I		give street an	nd number)	~		4b. City, Towr	n, or L	ocation of Death		4c.	County of De	ath	
1			Upper Ch	esapeak	ie					L A:				Harf		
	Funeral		5. Social Security Nur		. Sex 1 ⊠ M 2□		e (In yrs. las	t birthday) Yrs.	If Under 1 Ye Months Da		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h v, Year)		Country	ce (State or Foreign v)
	Director	-	214-34-16 Usual Residence of D				77	115.				5-12-19	931_		ld.	
	and sw	l l		10b. County			10c. City,	Town or Lo	cation						10d	I. Inside City Limits
	Mary	후	Md.	Harfo	rd			Joppa								1 □Yes X□No
	r 28a	Director	10e. Street and Numl	ber					10f. Zip Cod	de			10g. Cit	izen of What	Country	l?
	h with	aD	2901 W	. Frank	linvi	lle Rd	1.		2	2108	85			US	A	
	deat	Funeral	11. Marital Status		12. Was	Decedent E		13. \	Vas Decedent	of Hisp Cuban	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Al Black, Wi	mericar	n Indian,
92	or ite	F	1 Never Marrie		1 X	Yes 2□N s, Give	10		l∐Yes 21 ∑ II		Specify:	, , , , , , , , , , , , , , , , , , , ,		Specify:		ite
Ö	hours after death with the Maryland tural", or items 23a or 28a-f show al Evantium to invitted at	d by	3 ₩ Widowed 4		Year	r or Dates:					ian		16h K	ind of Busines		
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75	within 72 iene. than "na	mo M	Elementary/Second	dary (0-12)	Colle	ege (1-4or 5		ducat		,			S	School	Svs	tem
<u>Π</u> β	i filed I Hyg other	Be C	17. Father's Name (F	irst, Middle, La	st)					1	18. Mother's Nam	e (First, Middle,				
<u> </u>	Ald be Aenta Aenta rked tic ev	To B	Edwar	d D. Ry	an					2	Zella G.	Bennet	t			
8 /8/5 f. 21215-0036	2 short and I is ma		19a. Informant's Nar	me/Relationship	(Type. Print	t)	Į.	19b. Mailir	ng Address (Str	reet an	nd Number or Rui	ral Route Numbe	er, City o	or Town, State	e, Zip C	Code)
00≥	and 2 ealth n 27 ner tr	15.		K. Corr	elli_	TG					Lane P				128	
£ 0	t of H If iten	. 12	20a. Method of Dispo ¶☐ Burial 2 ☐		□Removal	from State	cen	netery, cren	sition (Name or natory or other	f place)		Date		ocation - City		
_8,5	tmen tant:	1	4 ☐ Donation 5	5 ☐ Other (Spe	cify)		Ho	11y H		_	8-2-2	800	Mid	ldle Ri	ver	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By a proportional to the Zi is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is invited from that the confilled at once.		21. Signature of Fun	eral Service Li	censee	- +	7	22	. Name and Ad	ddress	of Facility	himunek	Fun	neral H	lome	
	20200		23a. Part 1. Enter the	o dispass or o	mplications	that caused	dteah edt	Do not ent	9705 Be	ela:	ir Rd.	Notting	ham,	Md . 2	123	Approximate
			shock, or heart	t failure. List or	nly one cause	on each lin	ne.	Do not ent	or the mode of		_				li c	Approximate nterval Between Onset and Death
5	Physician /Medical		disease or condition resulting in death)	illar	a	Hype	a conseque	DIC	Kesp.	Car	tory to	allure				
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aring	executed in and ial-transit	Examiner	Cause (Disease or ir that initiated events	njury	C.										70	
38	ficate be executed physician and s the burial-transit	Ë	resulting in death) La	ast	Di	ue to (or as	a conseque	nce of):								
378	cate be physicia the bur	dical			d											
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26	w requires that the death certifice been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent in the past 12 n		1 🗆	Live birth	of pregnand 2 Fetal d	leath 3 🛭	Ectopic pregr					23d. Date of Month		y Day Year
\$00	he de r the a	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	lNo		Unknown	t time of dea	alii 5 L	Other (specify	y)						
£σ.	that the beat detail	h H	Part II. Other signific	cant condition	s contributing	g to death b	ut not resulti	ing in the u	nderlying cause	e giver	n in Part I.	23e. Did t	obacco	use contribute	e to the	cause of death?
SS	uires n sigr lld be	d by	Stage	I Non	Sma	11 ce	11/4	na Co	ancer	7		1 🗆 `	Yes 2	!□ No 3□	Proba	bly 4 Unknown
20	- 9 %	Completed	Lacyo	nonl	Can	cer						24a. Was		24b. Were	autops	sy findings available
30	The law ate has bage 2 s	mo	77	gen									osy rmed? 2 N No	death	to com 1? /es 2	pletion of cause of
<u>a</u>	sician; The certificate rector, pag	Φ	25. Was case referre	ed to medical							26. Place of Dea				165 2	
<u> </u>	Physician; this certific ral director, I	.0 B	examiner? 1∐Yes 2 ∑ N	No	Hospital:	1 Inpatie	ent 2 ☐ El	R/Outpatier	nt 3 DOA	Other	r: 4 Nursing H	ome 5 ☐ Resi	dence	6 □Other (S	Specify)	:=
20	ing Physician; The In. After this certificate hiteral director, page	L:uC	27. Manner of Death 1 ☑ Natural	5 Pending	28a.	Date of Inju (Month, Da	ry 2 y, Year)	28b. Time o	f 28c.	Injury Work?	at	28d. Describe	how inju	iry occurred		
Pig	ttending death. stor: After the funer	catic	2 Accident	investiga 6 ☐ Could no							es 2 □No					
<u> </u>	or Att	Certification: To	3 ☐ Suicide 4 ☐ Homicide	determin		Place of Injude	ury - At hom c. <i>(Specify)</i>	ne, farm, str	eet, factory, offi	ice		28f. Location (: City or To	Street a vn, Stat	nd Number oi e)	r Rural .	Route Number,
Division of Vital Records,	Hospital or A 24 hours after Funeral Dire rtely filled in b		29a. Certifier	10 Certifying	Physician	To the heet	of my knowl	ledge deat	h accurred at th	he tim	e date and place	and due to the	cause(s) and manne	r as sta	
3	Hos 24 hc Fun etely	Medical	(Check only one)	2 Medical E	kaminer: On and	the basis of manner sta	of examination at the state of	on and/or in	vestigation, in	my op	e, date and place inion, death occu	rred at the time,	date an	nd place, and	due to t	the cause(s)
Carlo	To the Hospital or Attend within 24 hours after deatt To the Funeral Director: completely filled in by the	Me	29b. Signature and t	itle of certifier	0 /	7 .		-			number			ate signed (M		lay, Year)
	- > - 0		1	/ay	1 By	ral			D	6	5905		Ju	114.2	0	2008
	2		30. Name and addre	ess of person w	ho completed	d cause of d	leath (Item 2	23a) (Type,	Print)	1				7	1	
	9	l ly	laria	IQI	sald	500 L	upper	Ches	apeak	21	5905 Dr. Be	IAir,	MI	241	014	<u>ł</u>

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Margaret Reichenbach /Medical July 26 5:30 AM 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Berlin Nursing & Rehab Worcester Berlin 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/31/1916 6. Sex Birthplace (State or Foreign Country) **Funeral** 215-10-8493 1 . M 200KF Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show r 28a-f sh notified MD Worcester Ocean City Director 1 **∑**Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe o 12301 Jamaica Ave. #109 G "natural", or items 23a 21842 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 21215-0036 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Rechenback, Margarent Baltimore, Maryland 21215-0 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 7 is marked other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Buck Mary Gorecki 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger H. Moore / 462 3rd Avenue Fox Island, WA 98333 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Dulaney Valley Mem 7/31/2008 Timonium, Maryland ₩Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service 22. Name and Address of Facility 1050 York Rd. Towson, MD Ruck Towson Funeral Home, Inc. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MITEROSCIERATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 1 Live birth 2 Fetal death 3 □Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by PERTENSION 1 Yes 2 No 3 Probably 4 Donknown - BRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an this certificate has ral director, page 2 2 100 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place o eath Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar HIMMAKAYA

JUL31

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32 Registrar's Signature

EASTERN SHORE DK, SALISBURY, MD 21804

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 3. Time of Death -0650_M 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** uly 2008 HELEN ELIZABETH RILEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL 112 WILSON BLVD. GLEN BURNIE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2√X F Months Days Hours Min. Director NOV. 12, 1954 MD 217.58.7479 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ---- any injury or other traumatic events. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Director 1 ☐ Yes 2 No MD ANNE ARUNDEL GLEN BURNIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 112 WILSON BLVD. 21061 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 1 ☐ Never Married 2√ Married 1 ☐ Yes 2XX No Specify. Specify: WHITE \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RILEY'S BODY SHOP 12 BOOKKEEPER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ DOROTHY ELIZABETH CHARLES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 HUSBAND 112 WILSON BLVD. GLEN BURNIE, MD CHARLES E. RILEY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XX Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN CEMETERY LAUG 4, 2008 GLEN BURNIE, MD Funeral Service Lice 22. Name and Address of Facility FINK FUNERAL HOME, P.A. M01148 426 CRAIN HWY. S., GLEN BURNIE, MD 23a. Part 1. Inter the diseast or commissations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart fail re. List only in cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LERASR **Physician** teriosale /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) it any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Principle of the physician and preciple of the physician and preciple. burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 Tyes director. 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 esidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DEput D06054 cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete 695 America 21035 31. Date filed (Month, Day, Year) State JUL 3 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Michael Thomas Richter 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A 9. Birthplace (State or Foreign Country)
Maryland f Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/14/1956 If Under 1 Year 7. Age (In yrs. last birthday) Security Funeral Months Days Min. 1 **X** M 2 □ F 51 Director 219 70 1947 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinat must be notified at 1 ☐ Yes 2 K No Director Port Deposit Cecil Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21904 U.S.A. 2010 Hopewell Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 Tayes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 □ No 1 ∐Yes 2 🗶 No Specify: Specify: Completed by White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver Cab Company 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patricia Croke Felix Richter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health at Important: If item 27 is any Injury or other trau 2010 Hopewell Road Port Deposit, Maryland 21904 <u>Joyce Ann Rich</u>ter / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/25/2008 | Baltimore, Maryland Holy Cross Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a, Part 1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Immediate Cause (Final Physician 1/10 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

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To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and

State Registrar 31. Date filed (Month, Day,

Year)

Baltimore, Maryland 21215-0036

P.0.

Records,

Division of Vital

d address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

			For State Registrar	State of Ma	aryland / Depa <i>Cel</i>	rtificate of I		-	giene _{Reg. No.} 2 (008	2465
2	Physici	an	1. Decedent's Name (First, Middle, La ALICE S • R	APHEL	- .			2. Date of De Month JULY	Day	Year 008	3. Time of Death 06:30p M
	/Medio	12	4a. Facility Name (If not institution, gir			4b. City, Town, or	r Location of Death	0011		ty of Death	
			15410 MANOR RD			MONKTO				IMOR	
	Funeral Director		197-22-2037	Sex 7. Ag 1 □ M 2 ▼ F	e (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da	/1928	9. Birth Cou PENN	place (State or Foreigr Intry) SYLVANIA
	ryland how at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	e Ma Ba-f s	cto	MD. BALTIN	MORE	MONKTO						1 ☐ Yes 2 No
	h with the	al Dire	10e. Street and Number 15410 MANOR RI)		10f. Zip Code 2111	1		10g. Citizen of USA		ntry?
36	be filed within 72 hours after death with the Maryland tial Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Spec	ace - Ameriack, White, ify: WH	
Maryland 21215-0036	nin 72 hou in "natura Medicai E	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed) College (1-4or 5	(Give	dent's Usual Occup kind of work done DO NOT use retired	oation during most of work d)	ing	16b. Kind of	Business/Ir	ndustry
212	filed with Hygiene other tha	Com		5+	TEAC	HER				ATIO	N
land	Schould be filed and Mental Hygi is marked other aumatic event, t	To Be	17. Father's Name (First, Middle, Las ADAM SMYSER	t)			18. Mother's Nam		, Maiden Surna	ame)	
	# 23 mg	•	19a. Informant's Name/Relationship EUGENE F • RAPI			ng Address (Street O MANOR					p Code)
Baltimore,	e = 5		20a. Method of Disposition 1 Bunal 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from State	20b. Place of Disponentery, cre	osition (Name of matory or other place ES CHURO	œ) CH 08/0	Date 09/200	20c. Location		
Baltir	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service Lice		2	2. Name and Addre HENRY W. 6924 YO	ss of Facility				
98760,	Physician and physician and as the burial-transit	ledical Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.	a consequence of):	factor the mode of dying factor with the second sec	ng, such as cardiac WE MYEL	or respiratory a	rrest,	6	Approximate Interval Between Onset and Death
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Δ.	uires that the de signed by the all be detached to	þ	Part II. Other significant conditions	contributing to death b	out not resulting in the u	ınderlying cause giv	en in Part I.	23e. Did			the cause of death? bbably 4 □Unknown
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Vita	Physician: this certificated director, it	Be	25. Was case referred to medical examiner?	Hospital:		at 3E DOA Oth	26. Place of Dea	th (Check only	one)		
ō	Phys r this ral dir	<u>۲</u>	1 Yes 2. No 27. Manner of Death	28a. Date of Inju		III 3 DOA	4 ☐ Nursing H	ome 5 Resi	how injury occ		ify)
Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	be 28e. Place of in	ury - At home, farm, st	M 1□	rk? Yes 2 □No	28f. Location (Street and Nur	mber or Rui	ral Route Number,
Ο̈́	pital or A ours after eral Dire		4 ☐ Homicide determined	building, e	of my knowledge, dea		ime date and place	City or To	wn, State)		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical			of examination and/or in		opinion, death occu			e, and due	to the cause(s)
	T Will	_	255. Signature and many certains	Mu	e my	DO(0336°	74	7/29	108	,, , , , , , , , , , , , , , , , , , , ,
	\$		30. Name and address of person who JOHN DOWNS M		death (Item 23a) (Type 5 OSLER D		ITE 302	TOWSO	N,MD.	2120)4.
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar	-	rtificate of L			eg. No. 201	08 3	2465	6
	Physicia	an	Decedent's Name (First, Middle, Last ROSA RAGLAND)				2. Date of Deat Month 7–23–		ear	ime of Death	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	7-23-	4c. County of		:43p ™	_
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ı	Funeral Director			THE OF YELL	01 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 4—18—1	907	VIRGII	State or Foreign	
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	se Mar 8a-f si	ctor	MD. N/A		BALTIMO						Yes 2 □ No	
	with the	Funeral Director	10e. Street and Number 4141 NORFOLK AV	E.		10f. Zip Code 21216		1	og. Citizen of What USA	it Country?		
	death	inera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.		ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-	14. Race -	American Ind	dian,	_
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and	be d o	Be	17. Father's Name (First, Middle, Last) HOWSON C. JOHNS				18. Mother's Name		Maiden Surname)			
Maryland	should be nd Menta marked ımatic ev	ပ္	19a. Informant's Name/Relationship (T	ype. Print)	19b. Mailir	ng Address (Street a	and Number or Run		r, City or Town, Sta	ate, Zip Code		_
	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		MARY E. JANEY (F	RIEND)	340	GARRISO	N BLVD. B	ALTIMOR	E, MARYL	AND 21	215	
Baltimore,	60 0		20a. Method of Disposition 1 🖾 Burial 2 🖸 Cremation 3 🗆 I	nemovar from State		sition (Name of natory or other plac			20c. Location - Cit	-		
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68760,	tificate be executed g physician and as the burial-transit	ledical		d	•		w					_
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Division of	il or Attu after de I Directo d in by ti	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	eet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Rou	te Number,	
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	To the within 2 To the comple	Me	29b. Signature and title of certifier	1 8		29c. Licens	e number	2	29d. Date signed (Month, Day,	Year)	_
	B		1/ Kithy	My,	Ny)	125	003		July 29	1 200	<i></i>	
	2		30. Name and address of person who c	1 1 1	m 23a) (Type,	Print) Charl	205 Ces St. 12	salts.	md 2	1205	L	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign		brack .						
	Registr	ar	AAF 9 T :	BEER WESTER	J. 1	SALA PROPERTY.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 1 per doc 9881 7-31-08 vt
State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 24657 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 Levin Stanley Jr. Month Year **Physician** July 28, Levin Stanley 10:10 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2925 Gwynns Falls Parkway Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F Director 213-22-8709 02 16 MD82 Usual Residence of Decedent filed within 72 hours after death with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or items 23a or 28a-f show the Medical Experiment the notified at 1 Yes 2 □ No Baltimore MD NA Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21216 2925 Gwynns Falls Parkway Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 TYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Š 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MD Toll Facilities i. Pages 1 and 2 should be filled wi itment of Health and Mental Hygien tent; if item 27 is marked other th ijury or other treumatic event, the Corporal 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Jews Levin J. Stanley Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2923 Gwynns Falls Parkway, Baltimore, Md 21216 partment of Health a portent; if item 27 is injury or other trea Lettie Stanley-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department o Importent: if eny injury or Owings Mills, Md Garrison Forest Vet 8/5/08 21. Signature of Funeral Service Licensee/ 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WYNONF CVO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of) Examiner ettending physicien and for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed 24 Division of Vital Records, P.O. Box 68760, 21 Due to (or as a consequence of) ABOD VAS Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Unknown 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate 1☐ Yes 2☐X0 director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Assidence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2 No 2 this 28c. Injury at Work? 27. Mannerof Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: 1 atural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident i Director: / d in by the f investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗀 Homicide within 24 hours el To the Funerei D completely filled i 29a, Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Actuallying Physician: 10 the best of my knowledge, death occurred at the line, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) fo the title of certifier 29b. Signature ar 29c. License number 29d. Date signed (Month, Dev. Year) 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 3 RS -5 <

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL31

2008

32 Registrar's Signature

ORIGINAL

			For State Registrar		aryland /	Depa Cer	rtificate of I	lealth a Death	and Menta	al Hygie Reg	ene 1. No. 2008	24658
1	Physici		1. Decedent's Name (First, Middle Mary Elizabe		nd				Mo	te of Death onth $1_{ m V}$.	30, Year 2008	3. Time of Death 5:25 A ^M
	/Medio Examir		4a. Facility Name (If not institution		<u> </u>		4b. City, Town, or	Location o		Ty .	4c. County of Deatl	
and a			South River Health &	Rehabilation	Center	t-1-11-1	Edgewa		24 Hrs 0 D	t (Di-th	Anne Ar	
	Funeral Director		243-30-1849 Usual Residence of Decedent	6. Sex 7. Ag 1 □ M 2 🗓 F	e (In yrs. last I 91	Yrs.	Months Days	Hours	Min. Jan	n 30,	fear 1917 Nor	hplace (State or Foreign untry) th Carolina
	yland how		10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	e Mar Ba-fsh	Director	2	Arundel	F	dgew	ater					1 □Yes 2 No
	with th	Dìre	10e. Street and Number	Dood			10f. Zip Code 210.	27		10g	g. Citizen of What Co	untry?
	ms 23	Funeral	144 Washington	12 Was Decedent	Ever in U.S.	13. \	Was Decedent of H		gin? (Specify Ye	es or No-	USA 14. Race - Amel	rican Indian,
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, It w Mcdleal Evar in actions to	by	1 ☐ Never Married 2 ☐ Marri 3 🕅 Widowed 4 ☐ Divorced	Armed Forces? ed 1 □ Yes 2 X If Yes, Give Year or Dates:	No		fYes, specify Cuba I∐Yes 2 ∑ No	Specify:	, Puerto Rican,	etc.)	Black, White	hite
15-(n 72 h "natu	lete	15. Decedent (Specify only highes	's Education t grade completed)	16	(Give	dent's Usual Occup kind of work done o OO NOT use retired	during most	of working	16	6b. Kind of Business/I	ndustry
212	y withii giene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		mer	"			Self Empl	oyed
pu	be filed tal Hy d othe event,	Be	17. Father's Name (First, Middle, I								iden Surname)	
ryla	2 should I and Men is marke	မ	Walter P. Stall 19a. Informant's Name/Relationsh		1	Ob Mailin	a Address (Street		Cora Ra		City or Town, State, Z	Tip Code)
Ma	alth an 27 is i		Jean Mitchell,							-	is, MD 214	, ,
ore,	jes 1 a t of He If item or othe		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □ Removal from State	20b. Place ceme	of Dispo	sition (Name of natory or other place	re)	Date	20	c. Location - City or	Town, State
ţ	permit. Pages 1 Department of I Important: If ite any Injury or of		4 □ Donation 5 □ Other (Sp	pecify)	Metro	100	matory I				Baltimore,	Maryland
Bal	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone.		21. Signature of Funeral Service. Thomas Grego	ry		2	99 Frede	rick E	Road Ba	ltimor	and, Inc. e, Maryla	nd 21228
O	Physician /Medical Examiner		23a. Part1, Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Care	ne.	s cu	er the mode of dyin		•			Approximate Interval Between Onset and Death
2 -	ed sit	iner	Sequentially list conditions, if any, leading to firm solution cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dive to for as	a écnesquene	e on:						
02	execute n and al-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequenc	e of):						
68760,	tificate be executed g physician and as the burial-transit	edical E		d								
	# B &	Med	IF FEMALE:	T								
P.O. Box	The law requires that the death certificate has been signed by the attending tragge 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal dea		Ectopic pregnanc Other (specify)	y			23d. Date of deli Month	ivery Day Year
	ss that gned b	by Pr	Part II. Other significant condition	ns contributing to death b	ut not resulting	g in the ur	nderlying cause give	en in Part I.	23	Be. Did toba	cco use contribute to	the cause of death?
ord	w requires t s been signe should be o						*			1 🗌 Yes	2 No 3 Pr	obably 4 Unknown
Division of Vital Records,	ician: The law certificate has b ector, page 2 sh	Completed								la. Was an autopsy performe ⊒Yes 2 ¶	prior to death?	topsy findings available completion of cause of 2 No
Vita	ysician: iis certific director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ☐ ER/0	O. 44:	t 3 DOA Othe		of Death (Chec		0.000	
o of	ding Phys h, After this funeral di	n: To	27. Manner of Death	28a. Date of Inju	ry 28b	outpatien Time of Injury	T O D DOX	4 7 1101			ce 6 Other (Specinjury occurred	cify)
sior	Attending Physician: or death. ector; After this certification in the funeral director; by	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ation			M 1 🗆	Yes 2□N	No			
Öİ	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	4 Homicide determi	ned 28e. Place of Injude	ury - At home, c. (Specify)	farm, stre	eet, factory, office		28f. Lo	cation (Stre ty or Town, t	et and Number or Ru State)	ral Route Number,
	ospital hours ineral y fillec	Sal	29a. Certifier 1 Certifyin.	g Physician: To the best	of my knowled	lge, death	occurred at the tir	ne, date an	d place, and du	e to the cau	use(s) and manner as	stated.
	the Hin 24 the Fi	Medical	one)	Examiner: On the basis of and manner sta	ated.	and/or in			th occurred at ti			
	Nit To		29b. Signature and title of certifier	\sim			29c. Licenso	5 3 7	5	1	I. Date signed (Month	
	0		30. Name and address of person v	vho completed cause of d	eath (Item 23a	a) (Type, I	Print)				1 312	, 2000
	3		KAJ CH	AWLA 1	4300			Fux	lane	STE	# 210	130 Wie MD 20715
	Sta Registr	_	31. Date filed (Month, Day, Year) JUL 3 1 20	32. Registr	ar's Signature	and.	م					20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JM1 28, 02008 Year Laverne Smith 9:28 A M 4b. City, Town, or Location of Death Catonsville 4c. County of Death Baltimore 4a. Eacility Name (If not institution, give street and number)
Ridgeway Manor Nursing Home 6. Sex 1 X M 2 □ F 8. Date of Birth
July 12, 1911 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 218**-**62**-**111**7** Days Hours Months Mary Land Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 X No Maryland Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 **USA** 6348 Frederick Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 □ Yes 2 No Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lily Raab (maiden name unknown) George Raab 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1002 Frederick Rd., Catonsville, MD 21228 Lou Weinkam - Lawyer Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemeters, crematory or other place) Method of Disposition Woodlawn Cemetery Burial 2 Gremation 3 Removal from State 07-31-08 Woodlawn, MD 4 □ Dobation | 3 □ Other (Specify) 22 Ambrose Fufferal Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final about Ihr disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day in the past 12 months? 1 □ Yes 2 No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation

Physician /Medical Examiner Physician/Medical Examiner law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral Director

Be Completed by

ည

Funeral

Director

d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Expaniest or 18st be rediffed at

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked i any injury or other traumatic ev

Baltimore, Maryland 21215-0036

burial-transi attending physician for use as the buria cate has been signed by the page 2 should be detached To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director: After this certificate h completely filled in by the funeral director, page

Completed by

Be

Certification: To

Medical

P.0.

Records,

Division of Vital

23b. Was decedent pregnant

3 Suicide

4 Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

6 Could not be determined

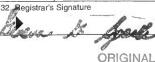
29c. License number

29d. Date signed (Month, Day, Year) July 28,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltomore, MD & 1287 MD 4367 RAJA

31. Date filed (Month, Day, Year) State Registrar



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 24660 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Aast) **Physician** 12:30 AM dul 1008 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner limole Good Samaritan HOS Ballimole If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 104 217-40. Director Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10b. County 1 DYes 2 No CIM Baltimore Director 10g. Citizen of What Country? 10e. Street and Number "natural", or Items 23a dical Examiner must b oneer Funeral filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 DAO If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other than 10th Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 Is
any injury or other trau Jean A. Shacklett Battimore, MD 21214

Date 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State of Faith 8-1-2008 Baltimore, MD 22. Name and Address of Facility Vougan C. Greene Funeral Services Garden of Faith 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MOL 4905 York Ad Baltimore, MD 21212 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical r as a consequence of): Due to two wee Examiner Sequentially list conditions Due to or as a co cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed for use as the burial-transit Due to (or as a consequence of); P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 MNo 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by 1 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Minknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an ate has b page 2 s this certificate 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 🔊 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUL 3 1

32. Registrar's Signature

			1 - For State Registrar	State of Ma	ıryland	d / Departme	ent of Health ate of Death			giene 00	8 24661
	Physici /Medio		1. Decedent's Name (First, Middle, L	ast)	1	urcot	Ł		Date of Dea Month		3. Time of Death
	Examir Funeral Director	er	4a. Facility Name (If not institution, g Social Security Number 212 07 3978	s Hospiet				er 24 Hrs. 8.	Date of Birti		Death OWL CO Birthplace (State or Foreign Country) Su Day Country
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Location					10d. Inside City Limits
	the Mar 28a-f st	ector	MD Word	cester		Whaleyv	ille Zip Code			10g. Citizen of Wha	1 Yes 2X No
	23a or	ai Dir	7752 Whaleyville	e Road			218	72		U.S.A.	
980	72 hours after death with the Maryland instural', or Iteme 23a or 28a-1 show digal Exeminar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forcas? 1 ☐ Yes 22 16 If Yes, Give Year or Dates:			cedent of Hispanic Copecify Cuban, Mexico		y Yes or No- an, etc.)	1	American Indian, White, etc. White
21215-0036	within ene. than "	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 7th	Education rade completed) College (1-4or 5	+)	life. DO NOT	work done during me	ost of working		Rag Proc	·
Maryland 2		To Be C	17. Father's Name (First, Middle, La. Weber G. L.					her's Name <i>(F</i> Iyrtle <i>1</i>		Maiden Sumame) Irer	
	d 2 s h an 7 is trau		19a. Informant's Name/Relationship Calvin Ronald Bu				ess (Street and Num Lleyville			r, City or Town, Sta Ville, MD	te, Zip Code) 21872
Baltimore,			20a. Method of Disposition 1 XX irial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Ce	ace of Disposition (formatery, crematory of traine Par	r other place)	y 7/3	1/08	20c. Location - City Woodlawr	
Balti	permit. Pages Department of Importent: If I any injury or once.		21. Signature of Funeral Service (fic	ensee	1	Burge 3631	and Address of Fac e-Henss-S Falls Roa	eitz Fi d Bali	meral to, MI	Home, Ir 21211	nc.
760,	Physician /Medical Examiner physician and physician and physician in p	ical Examiner	23a. Part1. Entir the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Congress C. Pillmena Due to (or as a decided of the congress) Due to (or as a decided of the congress)	Aspaconsequive	cisation from the Reart to ence of:	neumonia i lure				Approximate Interval Between Onset and Death Fe w days Few weeks Few weeks
.O. Box 68	The law requires that the death certificat sie hes been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3 □Ectopic				23d. Date of Month	f delivery Day Year
ds, P	uires that signed b	þ	Part II. Other significant conditions		1	Iting in the underlyin		t I.			te to the cause of death?
of Vital Records,		Completed	Hypertension, advanced age.	Osterporo.	sis.	0			24a. Was autop perfo 1 ☐ Yes	rmed? prior	e autopsy findings available r to completion of cause of th? Yes 2 No
Vite	Physician: The this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 🗆 E	ER/Outpatient 3	Other	ce of Death (C		n <i>e)</i> lence 6 □Other (Specify)
on of	De Te	tion: T	27. Manner of Death 1 Manural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injur (Month, Day	y	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 [280		now injury occurred	
Division	tel or Attending s efter death. el Director; After ed in by the fune	Certification:	3 Suicide 6 Could not 4 Homicide determine	be One Bless of Inju	iry - At hor : (Specify,	me, farm, street, fac	tory, office	28f	Location (S City or Tow		or Rural Route Number,
	To the Hospitel or At within 24 hours effer of to the Funerel Directompletely filled in by	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examinati	vledge, death occurr ion and/or investigat	ed at the time, date a on, in my opinion, de	and place, and eath occurred	due to the at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0			29c. License number			29d. Date signed (A	
	\		30. Name and address of person wh	o completed cause of de	č.	23a) (Type Print)	H006606	*		07/28/	× 00
	H		TONY GONSALVE	D.c. Dees	-s Hee	ed Hospit	nl, Salisb	ury, /	Maryl	and.	
(C)	Sta Registr	_	31. Date filed (Month, Day, Year)	32. Registra	irs Sionai	K Arias					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2.07 AM 07 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner are owso. der 1 Year | If Under 24 Hrs. >a/ Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1**™** M 2□ F Georgia 257-26-1201 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 □ Yes 2 **€ N**o Director OWSON 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be 21204 Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 M Yes 2 □ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 'natural', or 1 ☐ Yes 2 No Specify Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) h and Mental Hygie or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Jnfgrmant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: if item 27 is any Injury or other trau Son 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 1701 AC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclaroto Cardio vasular **Physician** /Medical Due to (or as a consequence of): Examiner phesen Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed neumor burial-tran Due to (or as a consequence of): physician Physician/Medical the attending j as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has teen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an p.ge 2 autopsy performed certificate Yes 2 No or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA ٩ this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 ☐ Homicide filled

Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 129/01 mier- ood 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltingo Rm 206 Contain street 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 3 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

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lan	Aenta Aenta rked tlc ev	5 8	Clarence W.	Vincent,	Sr.				Elain	e S	mith				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Muddal Evaminer must be notified at once.	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street	and Number o	r Rural I	Route Numb	er, City	or Town, State,	Zip Code)	
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	/Medical		resulting in death)	Due to (or as				HIVE	1146- 15	244.44	raci 4	U			
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	V - (30. Name and address of person who	completed cause of de	eath (Item :	23a) (Type,	Print)	V.K	16.10			J /	~ /		<u></u>
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 24664 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 8:19 Wright Jul 200% <u> Hortense</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Biltimore Harostal Bultimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 03 31 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2 🖾 F MDDirector 91 218-10-9222 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'v. Madical Eventina in ust be notified at Director Y Yes 2 □ No NA Baltimore MD 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code U.S.A 21209 4800 Yellowwood Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □No Specify. Specify: þ Black 3X Widowed 4 ☐ Divorced 2 should be filed within 72 hours and Mental Hygiene.

Is marked other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Cole 2 Alfred E. Floyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. 3701 Monterey Road, Baltimore, Md 21218 Floyd Wright-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 8/2/08 Owings Mills, Md 21. Signature of Funeral-Service Licensee Marchad Address of Facility t 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hear tailuk omestic o yeurs disease or condition resulting in death) /Medical Due to (r hs a consequence of) kaminer Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of): the attending physician a hed for use as the burial-Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ filter CAD SIP IVC 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an icate has t ; page 2 sl autopsy certificate 2 No 1 □Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ဥ : After thi Date of Injury (Month, Day, Year) 28c. Injury at Work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,2401 W. Beludike I that Hospital of QUITUB 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Deple 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July ^{Day} 2008 26, 10:57 A M Joseph Wisniewski 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore County Henry Avenue Nottingham If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 1-10-1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours Min. Md. 78 217-24-8182 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Tyes 2 No Md. Balto. Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 USA 5125 Henry Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian. Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2 🗓 No Specify. Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Staff Sgt. U.S. Government 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Borsukowicz John Wisniewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5125 Henry Avenue Nottingham, Md. 21236 Lorraine Wisniewski Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-30-2008 Parkwood Parkwood 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licenses Buin a. 19705 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISEASE 1-LEART ZYEARS ONGESTIVE disease or condition resulting in death) Due to (or as a consequence of): CANCE UNGI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items any injury or other traumatic event, it of Mexical Examinar manages.

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Pages 1 and 2 should be filed within 72 hours after

Saltimore, Maryland 21215-0036

Director

Funeral

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Completed

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and burial-tran attending physician for use as the buria sate has been signed by the page 2 should be detached certificate filled in by the funeral director. 24 hours after death.

Funeral Director: After this

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical \$ Completed Be Medical Certification: To 27. Manner of Death

1 Yes 2 No

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

3 Suicide 4 Homicide 29a. Certifier

1 Natural

2 Accident

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier

D52279

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TO REISTERTOWN ROAD, DWINGS MILLS ZILLY-SRIRAM H-BALASUBRAMANIAN MD ICZIO REISTERTOWN ROAD, DWINGS MILLS ZILLY-

State

Registrar

31. Date filed (Month, Day, Year)

JUL 3 1 2008

2. Registrar's Signature

To the Hosp within 24 hor To the Fune completely fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 July 26, **Physician** Unknown M Robert Clayton Wright /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3710 Songbird Circle Baltimore Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Apr. 18, 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** . 19<u>31</u> Months Days Hours Min **t√**ZM 2□ F Maryland 216-28-7039 77 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Eventral control once. 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Director MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3710 Songbird Circle 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1 □ Yes 2 XNo White Specify. þ Specify: 3X Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Grinder Koppers Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elvin Wright Ruth Borman ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3719 Songbird Circle, Baltimore, MD 21227 Cynthia Ann Wright 20b. Place of Disposition (Name of pemetery, grematory or ather place) To Burial 2X Cremation 3 Removal from State 4 Obnation 5 Other (Specify) Date 20c. Location - City or Town, State 20a. Method of Disposition 8-4-2008 Odenton, MD Crematory 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as e consequence of): Examiner ischemi Sequentistly list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine MANYSEMA Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X**No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician as the t for use certificate has been signed by the rector, page 2 should be detached 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, I completely within 2 To the I the

burial-trar

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address

29b. Signature and title of certifie

son who completed cause of death (Item 23a) (Type, Print) SchWART MD 32. Begistrar's Signature

Attendina

ORIGINAL

29c. License number

3512 Newland

29d. Date signed (Month, Day, Year)

and manner stated.

		1	For State Registrar	te of Maryland		artment of He tificate of D		Re	g. No. U U (
	Physicia	72	Decedent's Name (First, Middle, Last)	h. Tdo Nobe	-t			2. Date of Deat Month July		3. Time of Death 11:10 P.M
	/Medic	al	DOFOT Aa. Facility Name (If not institution, give street a	chy Ida Webs	ster	4b. City, Town, or	Location of Dea		4c. County of	,0
	Examin	er	Genesis Eldercare Ham			Balti	more		Anne A	rundel *
1	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las MF 98	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day,	Year) 9	Birthplace (State or Foreign Country) Maryland
4	Director		213 01 7469 1 M 21	98	115.			03/28/1	910	maryianu
	nyland how		10a. State 10b. County		Town or Lo					10d. Inside City Limits
	Ba-1 s	ctor	Maryland Anne Arun	del B	altim				Og. Citizen of Wha	1 Tyes 2 X No
	with the		10e. Street and Number 613 Hammonds Lane			10f. Zip Code	225	'	U.S.A	•
	death ma 23	erai	11 Marital Status 12. Wa	s Decedent Ever in U.S.	13.	Was Decedent of His f Yes, specify Cubar		Specify Yes or No-	14. Race -	American Indian, White, etc.
9	72 hours after death with the Maryland natural; or Itema 23a or 28a-1 show Iteal Exacitat must be notitled at	by Funeral Director	1 Never Married 2 Married 1 St Y	ned Forces?]Yes 2 🚨 No es, Give		1 Tes, specify Cubar 1 ☐ Yes 2 🖾 No		to rican, etc.)	Specify:	
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IZ	2 should be and Mental Is marked or raumatic even	2	19a. Informant's Name/Relationship (Type, Pri			ng Address (Street a		rgaret Lo Tural Route Number		
Ma	alth ar 27 is		Louise M. Stull / s	ster	2510	Tigani D	rive	Wilming	ton, Dela	aware 19808
Baltimore,	of Hei	1	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Remova	20b. Pla	netery, crei	sition (Name of matory or other place			20c. Location - Ci	
Ë	Pag tment tant: I		4 □ Donation 5 □ Other (Specify)	Ceda		ll Cemeter		27, 2000		re, Maryland
Bal	permit. Pages 1 an Department of Heali Important: If item 2 sny injury or other <u>905e</u> .		21. Signature of Foneral Service Lisensee	udge	4	4001 Ritch	nie High	way Balt	cimore, N	vice, P.A. Maryland 21225
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	se on each line.						Approximate Interval Between Onset and Death
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ecc	e law re has be	Completed	OLD STROKE					24a. Was a autop: perfor	sv pri	ere autopsy findings available or to completion of cause of ath?
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Zi.	ysician: is certific director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospita	ll: 1 □ Inpatient 2 □ E	R/Outpatie	nt 3 DOA Othe		eath (Check only or Home 5 Resid		(Specify)
ı of	ding Phy I. After this funeral o				28b. Time o				ow injury occurred	
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Division of Vital Records,	or Att	Certification:	4 Homicide determined 286	 Place of Injury - At hor building, etc. (Specify) 		reet, factory, office		City or Tow		or Rural Route Number,
_	To the Hospital or Attending the Completely filled in by the completely filled in by the		29a. Certifier 1 Certifying Physician	To the best of my know	rledge, dea	th occurred at the tim	ne, date and pla	ce, and due to the o	ause(s) and man	ner as stated.
	he Ho in 24 t he Fu pletely	Medical		n the basis of examination of manner stated.	on and/or ir					
	To t To t	Σ	29b. Signature and title of certifier	~ ~ ~		29c. License				(Month, Day, Year)
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4			30. Name and address of person who complete	ed cause of death (Item		- 4 AN	SUGR	57, 6	ALTIA	28, 2008 MORE 2125
15		ate	31. Date filed (Month, Day, Year)	32. Registrar's Pignati	1034					
2	Regist	rar	10F 9 T 5000		A					

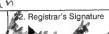
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 8:15 **Physician** Wetters Jr. lohn 2008 JV14 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A The Johns Hopkins Hospital **Baltimore City** Date of Birth (Month, Day, Year) 08/29/1937 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F 70 Maryland 215 34 8738 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Directo Anne Arundel Baltimore Maryland 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ö U.S.A. 21225 or items 23a 738 Old Riverside Road mit. Pages 1 and 2 should be filed within 72 hours after death partment of Health and Mental Hygiene. ortant: If item 27 Is marked other than "natural", or items 23. injury or other traumatic event, the Medical Examiner must in Injury or other traumatic event, the Medical Examiner must Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 The street of the stre 2 X No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: δ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Long Shoreman Shipping 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be John G. Wetter Sr. Hedwig Lonczynski ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 738 Old Riverside Road Baltimore, Maryland 21225 Susan Wetters / Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State permit. Page Department of important: If any injury or once. 5 Other (Specify) Baltimore, Maryland Bayview Crematory 08/02/2008 4 \ Donation eral Servine Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Extended disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Leukemia Acute 4e logenous **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3
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To the Funeral I

completely filled the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 🗹 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number -29b. Signature and title of cont

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Tahd Kahman
31. Date filed (Month, Day, Year)
JUL 3 1 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

600 North Wolfe St, Baltimore, MD, 21287

2008

State Registrar RES

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 28, 2008 2:15 р. м July Emily S. Wood /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Baltimore Co. Timonium 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**) F Months Days Hours 90 Director 170-12-0355 Oct. 25, 1917 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10h. County ed other than "natural", or items 23a or 28a-f show event, the Medical Evan than rust be notified at 1 ☐ Yes 2√☐ No Director Baltimore Co. Maryland Carney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Widebrook Court 21234 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X□No Specify: Completed by Specify: 3

Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked ofth any injury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Brinton Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. George W. Wood, III /Son 2 Widebrook Ct. Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Mem. Park AUG 1,2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee Michael E. Canapp 22. Name and Address of Facility 5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each me Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be execut attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ bo Month Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Division of Vital 2 No 1 □Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No eral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and 7.28.08 5 RM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 2300 DULANEY VALLEY ROAD EDDIE NAKHUDA, M.D. A. Pay 31. Date filed (Month, Da Year) Registrar's Signature State

Registrar

2008

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
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			For State Registrar	tate of Maryla	•	rtment of H tificate of L		lental Hyg	g. No. 2008	3 24671	
	Physici							th Day Year <i>15 200</i>	M		
/Medic Examin			4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center 4b. City, Town, or Location of Death 4c. Con Salisbury 4c. Con						4c. County of Dea	ath NICO	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Madical Evanina must be notified at once.	To Be Completed by Funeral Director	Months Days Hours Min. Of Month Days Country					rthplace (State or Foreign ountry) Delaware			
			10a. State 10b. County Delaware Sussex	City, Town or Lor Seaford	City, Town or Location Seaford				10d. Inside City Limits 1 □ Yes 2\ No		
			10e. Street and Number 6263 Boyce Rd			10f. Zip Code 19973			0g. Citizen of What C		
Baltimore, Maryland 21215-0036			11. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	Was Decedent Ever in Armed Forces? 1 ∐Yes 2⁴ No If Yes, Give Year or Dates:	1	□Yes 2☑No	ispanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	ite, etc. ite	
			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5		+) 16a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired) CEO		ation furing most of worki)	most of working		b. Kind of Business/Industry Printing	
			17. Father's Name (First, Middle, Last) Thomas E. Ayers					(First, Middle, Maiden Surname) et Layton			
			19a. Informant's Name/Relationship <i>(Type.</i> Elizabeth Ayers – v				and Number or Rura , Seaford	l, DE 19			
			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)		b. Place of Dispo cemetery, cren Capitol (sition (Name of natory or other plac Crematory	e) !		20c. Location - City o Dover, DE	r Town, State	
Bal			21. Signature Funeral Armost License Crains to P O Box 967, Seaford, DE 19973								
	Physician /Medical Examiner	ledical Certification: To Be Completed by Physician/Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Approximate Interval Between Onset and Death Froutier Due to (or as a consequence of):								
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death certificate best been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	consequence of):						
			that initiated events resulting in death) Last	Due to (or as a cons	consequence of):						
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	lecedent pregnant past 12 months? es 2 \(\subseteq \text{No} \) 23c. If yes, outcome of pregnancy 1 \(\subseteq \text{Live birth} \) 2 \(\subseteq \text{Fetal death} \) 3 \(\subseteq \text{Ectopic pregnancy} \) 4 \(\subseteq \text{Pregnant time of death} \) 5 \(\subseteq \text{Other (specify)} \) 4 \(\subseteq \text{Pregnant time of death} \) 5 \(\subseteq \text{Other (specify)} \)					23d. Date of d	23d. Date of delivery Month Day Year	
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown								
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Division of Vital Records,			25. Was case referred to medical examiner?							s 2 No	
			1							ecify)	
			2 Accident investigation	7/H/08 28e. Place of Injury - A building, etc. (Sp 1+om	ry - At home, farm, street, factory, office 28f. Location (S City or Tow			Street and Number or Rural Route Number, rn, State)			
			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	Vithin comply	Me	29b. Signature and hild of certifier			29c. License	(240		7/15/08	nth, Day, Year)	
	Indn		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salts by W								
State Registrar 31. Date filed (Month, Day, Year) JUL 18 2008 32. Sgistrar's Signature											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 8 per phys. mf881 Certificate of Death Reg. No. 1 - For Amend Item 1 Registrar Reg. No. 1. Decement's Name (First, Middle, Last), 2. Date of Death 3. Time of Death **Physician** Barbara Barnhart /Medical Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner OF UNIVEVS144 altimore Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) February 16,1948 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex (In yrs. last birthday) **Funeral** Months Days Hours Country 1 M 2 F Yrs. Director 169-38-7209 60 WV Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Wedical Examinations to motified at Director 1X Yes 2 No Berkeley Springs Morgan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 25411 18 Hudson Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Presser Clothing Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Alderton Grely Yost ၉ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 62 Warfordsburg, PA 17267 Jason Barnhart/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Injury Warfordsburg Presbyterian 107/19/2008 Warfordsburg, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 141 West Main Street 21. Signature of Funeral Service Licenses Grove Funeral Home, P.A.Hancock, MD 21750-0368 23a. Part 1. Enter the disease of com shock, or heart failure. List only ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of) Examiner Failli Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) the been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed s certificate has b 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c 1 Anpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Consider the time, date and place, and due to the cause(s) and manner as stated.

Consider the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical hd manner stated. 29b. Signature d title of certifie 29c. License number 31. Date filed (Month, Day, Registrar's Signatur State

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Registrar

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Brutkiewicz July 23, 2008 9:45 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 41209 Queen Arbor Court Mechanicsville St. Mary's Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 M 2 X F 198-50-5065 48 Director Dec. 10, 1959 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41209 Queen Arbor Court 20659 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White Completed the Medicai 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Contract Specialist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Buzinski Pau1 မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Gregory Brutkiewicz/Spouse</u> 41209 Queen Arbor Court, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Brinsfield-Echols 7/25/2008 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 Kyle S. Simons MOr206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CANCER PANCREATIL **Physician** METASTATIC 15 months resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours after death the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 50686 Estla 7/24/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CH HABRA, ROAD, (ALIFORNIA, MD CTURDEEP.S. 23415 THREE NOTCH Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** P^{M} July Wilma 8:55 23 2008 /Medical Brown 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 9. Birthplace (State or Foreign Country) Mary Land If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Nov. 5, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 88 Yrs. 1919 218-09-0047 Director Nov. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at XXYes 2 □ No Director Frederick Frederick Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death with U.S.A. 21702 1421 Taney Ave., Apt. 523 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", or ite 1 ∐Yes ŽXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 🏋 No Specify Specify: ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 11 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Mary Catherine Haines Earl Roscoe Harsher ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai 11 Rosebud Court, Unit 105, Woodsboro, MD 21798 Charles E. Brown, son timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Lutheran Cemetery July 26, 2008 Middletown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2KName and Address of Easily ford PA Funeral Home MOO255 106 East Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final piratory Distress **Physician** disease or condition resulting in death) /Medical Que to (or as a conse n e ... e of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial nding physiclan use as the burial Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atter for u Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 4 🔲 Pregnant at time of death signed by the 1 ☐ Yes 2 ☑ No Ö 9 Unknown 9 Unknown ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by scleropic artriovascular 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 □No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this 27. Manny of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: Division Hospital or Attending 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 25, 2008 D0054636 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 Montclaire Ave., Frederick, MD 21701 Sved W. Haque, M.D., 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physici<u>an</u> Day Month 24, MAUD SYLVETTA July 5:10 PM BARTHOLOW 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Madonna Heritage Jarrettsville Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | 4/3/1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 291-14-2901 88 Director Ohio Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits Show notified at 1 ☐ Yes 2 X No Funeral Director Harford MD. Bel Air 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Item 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 10 Roland Place 21014 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status s filed within 72 hours after du Il Hygiene. other than "natural", or item ☐Yes 2 No f Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Be Completed by Specify. 3 Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be f nent of Health and Mental I Alpheus Raymond Farmer Dorothy Margaret 19a. Informant's Name/Relationship (Type. Prograndson) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles R. Wellington lll Colvard Court Forest Hill, MD. 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/26/08 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsvi

23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Jarrettsville, Maryland Immediate Cause (Final **Physician** Domentia Jears resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Ir jury) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 2-1No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assured Countries Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed Month, Day, Year)

JUL 3

100esz

1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5701

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Kenwood

32. Registrar's Signature

ORIGINAL

29c. License number

D31290

Baltimore

md

29d. Date signed (Month, Day, Year)

21206

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at once.

3altimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760 P.O. Division of Vital Records.

WI

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - For State Registrar 24677 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day July 16, 2008 Beulah Anne Belt 0635 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Carroll Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 🕱 F Yrs. July 11 1910 Maryland 98 214-18-0967 Usual Residence of Decedent 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 No Finksburg Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2261 Old Westminster Pike 21048 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No þ Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Beulah Brown Heckart William Thomas Marvel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Finksburg, MD 21048 Carole Stencil 2410 Shawnee Dr. Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ™ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Park 7/21/2008 | Glen Burnie, Maryland 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Ligensee - K x 412 Washington Rd. Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final demen disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Junswith Mi D 51705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANSURIYA 349 May colv Westminster MD 21157 349 Mal colm DR , 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Gloren & Sports Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 8 24678 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Vear **Physician** EILEEN VIRGINIA BRADSHAW CAULK 2008 9 10:30PM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Glade Valley Nursing Home Walkersville Frederick if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Days Hours 1 □ M 2 □ TF 199-03-1799 87 Director Maryland 5/20/1921 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Haalth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23s or 28s-1 show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits f Haatth and Mental Hygiene. Item 27 is merked other than "natural", or items 23a or 28a-f shov other traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Caroline Federalsburg 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 5225 Preston Road United States 21632 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 € Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Reginald Brooks Bradshaw Hester Virginia Hackett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nelda C. Cassell/Daughter 4217 Springview Ct. Jefferson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hill Crest Cemetery 7/23 Federalsburg, MD 22. Name and Address of Facility
Framptom Funeral Home, PA 21. Signature of Funeral Service Licensee Mn.St.Federalsburg, 216 N. 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? has 22 No 1 Yas 1 ☐ Yes 2 ☐ No certificata Be 25. Was case referred to medical 26. Place of Death (Check only one) 7 Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death
1 DNatural
2 □ Accident 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c 28d. Describe how injury occurred Injury at Work? 5 Pending investigation Iniun 1 ☐ Yes 2 ☐ No

Division of Vital Records, P.O. Box 68760, tor: Aftar this death. Director: in by within 24 hours at To the Funeral D complataly filled i

State

cal

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dale and place, and due to the cause(s) and manner as stated. 2 Demonstrate Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ar's Signature

and manner stated

and address of person who completed cause of deeth (Item 23a) (Type, Print) SON

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Dey, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 13, Day 2008 Year Patrick Culbert, Sr. 12:25 PM Roy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George 12607 Crozet Drive Upper Marlboro 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 0ct 5, 1934 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Days **1**√2 M 2□ F South Africa 386 30 4985 73 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evantium the collising at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Upper Marlboro 1 □ Yes 2 Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12607 Crozet Drive 20772 United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 XX 2 □ No
If Yes, Give Viet Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes **XX**No Vietnam If Yes, Give Year or Dates: \$ SpecifyWhite 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (174or 5+) Master Sgt Air Force Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Culbert Tousignant Blanche မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12607 Crozet Drive, Upper Marlboro, MD 20772 Celia Ortiz Culbert (Wife) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Lee Crematory July 15, 2008 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 21. Si nature of Funeral Service 22. Name and Address of Facility Lee Funeral Rome, Inc 6633 01d Alexandria Ferry Road, Clinton, MD leade, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. 23a, Part 1, Ente tof the diseas neart failure. Approximate Interval Between Onset and Death shock, or Immediate Luse (Hall disease or Indition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed' certificate 1 □Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the f 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

D 23743

MD

20707

29d. Date signed (Month, Day, Year)

14,2008

and manner stated.

Martin Weltz, M.D. 7350 Van Dusen Street, Laurel.

32. Pagistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend Items 21 & 22 per FH mf Certificate of Death

Reg. No. Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20 Physician 06 19:20 M LOTTE Mae CAMPBELL 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mary lan Clinton Southern Hospita MO 20735 Clinton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Year) Days Hours Min. 1 □ M 2 7 87 007-20-7247 Maine 25 Director 1921 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X XNo Director Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23a or the Medical Examiner must be 9211 Stuart Lane 20735 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Caucasian 2 3 V Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi 27 is marked t and 2 should b Health and Ment Sinton Unknown James ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Glenn Campbell Son 2004 Trumbull Ct. Virginia Beach, VA 23464 other t Department of Heal Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Woodlawn Mem.Gardens ⊹6/24/2008 Norfolk, Virginia 22. Name and Address of Facility Snellings Funeral Home 21. Signature of Funeral Service Licensee Amanda Ergler Roll : 8464 TIDEWATER DR, VA 23518 Old Alex. hello 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrested. Clintonia part Survey and Surve Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division or Vital Records, P.6. Box 68760. Physician/Medical the attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 Ø No Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has to autopsy perform certificate | 1∐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: f.fter the Hospital or Attending 5 Pending investigation 1 Natural in 24 hours after the funeral Director: After Funeral Director: After funeral tilled in by the funeral 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 2 52741 Uso 108. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ft Washing ton 11701 Lyngston Re

State Registrar

Caine

2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

3. Registrar's Signature

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DHMH 17 Rev 1/2001

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 July **Physician** 5:31 Pm Joyce Harden Duckett 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gwynndale Drive Prince George's Clinton If Under 1 Year | if Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Pay, Year) Aug 14, 1931 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months i Days Utah 578 38 9515 76 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼No Directo Prince George's Maryland | Clinton 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 9662 Gwynndale Drive 20735 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes **P** No If Yes, Give A Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ♥ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Banker Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Thomas Harden Margaret Chapman ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Duckett (Son) 9662 Gwynndale Drive, Clinton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 22, Date 2008 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, inc 21. Signature of Funeral Service Licensee 6633 Old alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed for use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home ပ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D0055/20 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) avenue SE Shite 310 Washington 1328 Southern mi 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State

Registrar

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** NON JUZ 1 8000 M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bealsville 9801 mon 00/6501/16 Omers If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) JULY 20 1954 9. Birthplace (State or Foreign Country) KY 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□F 165-46-3114 53 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at PA BUTLER SLIPPERY ROCK 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 228 CURRIE ROAD 16057 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 N If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify WHITE 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROFESSOR EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WARREN DIXON GLADYS FIELDS ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16057 AMY DIXON / SPOUSE 228 CURRIE RD., SLIPPERY ROCK, PA 20b. Place of Disposition (Name of 20a, Method of Disposition Date WEST LIBERTY BORO WEST LIBERTY CEMET. 7/21/08 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BUTLER CO., PA 22. Name and Address of Facility
HILTON FUNERAL HOME 21. Signature o P.O. BOX 86, BARNESVILLE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician MIK disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Clause Uniscase or injury that initiated events Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cate has been significant page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA his 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No al or Attend after death the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sid ture and title of certifier Im OmE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210 BRECHEK, MO OME 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

				artment of Health and rtificate of Death	Reg.	2000 24004
	Physici /Medic		1. Decedent's Name (First, Middle, Last) IRMA Sophia Denta		2. Date of Death Month July 21,	Day Year 3. Time of Death 4:05 pm
*	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	th	4c. County of Death
			16816 Three Notch Road 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)	Dameron If Under 1 Year If Under 24 Hrs	Doto of Dirth	St. Mary's
	Funeral Director		5. Social Security Number 16. Sex 1	Months Days Hours Min.		9. Birthplace (State or Foreign Country) 26 Pennsylvania
7	. A.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
Mond	a-f sho	ķ	Maryland St. Mary's Dameron			1 □Yes 2 🕅 No
Section of the Manager	or 28 De not	Directo	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
40	1s 23g	Funeral	16816 Three Notch Road 11 Marital Status 12. Was Decedent Ever in U.S. 13.	20628 Was Decedent of Hispanic Origin? (S		nited States
130 130	Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once.	by Fun	1 Never Married 2 Married 1 TYes 2 MNo	was Decedent of Hispanic Origin / (s) If Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 ☒No Specify:	to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
3-0036	natura lical E		15. Decedent's Education 16a. Dece	dent's Usual Occupation	168	White b. Kind of Business/Industry
7	han "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of wo DO NOT use retired)	1	1
7 D	Hygie other t	Be Co	12 Offic 17. Father's Name (First, Middle, Last)	e Manager 18. Mother's Nai	me (First, Middle, Mai	egal den Surname)
/lan	Mental Mental urked out	To B	Charles Devetz	Viktoria	Barczy	
ar)	and I	ľ	19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or R	ural Route Number, C	ity or Town, State, Zip Code)
e, 1	Health em 27 ther to			Three Notch Road		, MD 20628 c. Location - City or Town, State
TIOL	nent of I		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cree	osition (Name of matory or other place)		eltenham, Maryland
altimor	Departm Importar any inju		/	D. Manne and Address of Facility	•	Funeral Home, P.A.
ם פ	29 = 29		•	2955 Hollywood Ro	oad, Leonar	rdtown, MD 20650
Di	hysician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	er the mode of dying, such as cardia	c or respiratory arrest	, Approximate Interval Between Onset and Death
	Medical xaminer physician and physician and physician sit physician and	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	rentive Ling	D) 52	
O. DOX of	signed by the attending physician and be detached for use as the burial-transit	Physician/Med		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
US, T.	signed by d be detac	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	1.00	co use contribute to the cause of death?
ecorus law requires	s been s	lete		-	24a. Was an	24b. Were autopsy findings available
Cian: The la	ificate ha or, page 2	Completed	25. Was case referred to medical		autopsy performed 1 ☐ Yes 2 7	prior to completion of cause of death?
Vsicia	s cert	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	Other:	ath (Check only one)	e 6 □Other (Specify)
5 6	fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe how i	
IVISIOII	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 and present of the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined building, etc. (Specify)	M 1 □Yes 2 □No	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
Lospital c	4 hours a Funeral D ely filled i		29a. Certifier (Check only Certifying Physician: To the best of my knowledge, deat Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and plac	e, and due to the causurred at the time. date	se(s) and manner as stated. and place, and due to the cause(s)
o the l	ithin 2 b the I	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
ř	s ⊨ ŏ		Joanfut Moon luD	D09128		7/21/2017
•			30. Name and address of person who completed cause of death (Item 23a) (Type,	7		(11/200/)
			Youngsik Moon, M.D. 24435 Mervell De 31. Date filed (Month, Day, Year) 2000 32. Jegistrar's Signature	ean Road, Hollywo	od, MD 20	636
	Sta Registr		31. Date filed (Month, Day, Year) 32. Signature 32. Signature 32. Signature 32. Signature 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 32. Signature 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Date filed (Month, Day, Year) 36. Date filed (Month, Day, Year) 37. Date filed (Month, Day, Year) 38. Date filed (Month, Day, Year) 38. Date filed (Month, Day, Year) 39.	and the same of th		

08-05572 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Edward Regis Dowling State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 21, 2008 **Medical Examiner** 0825 hrs Edward Regis Dowling 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel # 2 13th Avenue Brooklyn 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) Funeral oreign Pennsylvania Months Days Hours Min. Director Country) 213-88-7188 1 X M 2 45 Yrs 1963 21 Tan. Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location 10b. County 1 Yes 2X No "natural", or items 23a or 28a-f show Examiner must be notified at once. MD Frederick Middletown Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3405 Marbury Ct. 21769 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. Never Married 2 X Married 2X No Yes Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after c
Department of Health and Mental Hygiene.
Important: fitem 27 is marked other than "natural", of
injury or other traumatic event, the Medical Examiner m If Yes, Give Year 3 Yes 2 X No specify: Widowed Divorced Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pressman Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Dowling Patricia Flaherty ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3405 Marbury Ct., Middletown, MD 21769 <u>Edward Dowling / Father</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Burial 2 XCremation 3 crematory or other place) Removal from State 7/29/2008 Frederick, MD Donation 5 Other Specify: Frederick Crematory 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 Courtney Stauffer, per DVR 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death Mixed drug (Cocaine & Morphine) intoxication ≒xaminer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit cal FD, G882 8/8/08 TT #21, per FD, G882 8/8/08 TT 23a,27,28a-f,perME, g882 8/29/08 TT X AMENDED attending physician or use as the burial -X UNPENDED Physician/Medi Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death or use as 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown ned by the a 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed ector, page 2 should be dete \$ σ. 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 No 1 🗸 Yes No 26.Place of Death (Check only one) director 25. Was case referred to medical Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this ٩ 1 ✔ Yes No After th 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: 1 Natural Pending Yes 2 X No unk Fnd 7/21/08 Fnd 8:!5 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State #2 13th Ave.

Brooklyn, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide (Specify) found at residence determined Brooklyn, 4 Homicide

the Hospit II or Attending Physician: The law requires that the death certificate be executed Division of Vital

within 24 hours arter within 74 the Funeral Director: Af

State Registra

Medical

29a. Certifier 1

29b. Signature and title of certifier

Russell Alexander MD.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Assistant Medical Examiner

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 1, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 14 pay 2008 SHIRLEY P. DAHLGREN 0003 AM

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O.

4a. Facility Name (If not institution, give street and number)

Homewood at Crumland Farms

Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County Maryland Frederick Frederick Directo 10e. Street and Number 10f. Zip Code 21701 7407 Willow Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) Be Lou Pumphrey ဥ Ruth Howard 19a. Informant's Name/Relationship (Type. Print) James H. Dahlgren / Son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 □ Donation 5 □ Other (Specify) 7/15/08 Smithsburg Crematory 21. Sanature of Fun Se 23a. Part1. Enter the disease shock, or heart failure. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-tran and Due to (or as a consequence of): signed by the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 Yes 2 No 9 Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I been 24a. Was an has autopsy this certificate 25 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) PL No Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 27 Manner & Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of pel ompleted cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, 32. Registrar's Signature State

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct (Month Day, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 217-12-2425 1 ☐ M 2 🔀 F 83 Missouri Director filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country? U.S.A. Race - American Indian Black, White, etc. Specify: White 16b. Kind of Business/Industry Own Home 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6619 Christy Acres Circle, Mt. Airy, MD 21771 20c. Location - City or Town, State Smithsburg, Maryland 22. Name and Address of Facility
ROBERT E. DAILEY & SON FUNERAL HOMES, NORTH MARKET ST., FREDERICK, MD Physician /Medical Examiner The law requires that the death certificate be executed 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 25 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Physician: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Hospital or Attending atter death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a **Descriptions** Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 July 12 6:03 A Roger Lee Eggers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Memorial Hospital Talbot Easton If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, June 20 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 216-64-9993 53 1955 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deportment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 1 Yes 2 □ No Director Maryland Caroline Goldsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15126 21636 USA Drapers Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates: 2 🗓 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify White Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 disabled N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph K. Eggers Oma Cook Graham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15126 Drapers Mill Road; Goldsboro, Maryland 21636 Denise Baker/ companion 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery | 07/18/08 Greensboro, Maryland 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, 21. Signature of Funeral Service Licensee PO Box 160; Greensboro, Maryland 21639 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** orgestive /Medical Due to (uses a consequence of), Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed Due to (or as a consequence of): burial-transi Exami ed by the attending physician detached for use as the buria P.O. Box 68760 Physician/Medical 6, lateral for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2**X** No 1□ Yes Division or Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation To the root.

Within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) w/) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 5 2008 Registrar

DHMH 17 Rev 1/2001

State Registrar

30. Name and address

31 Date filed (Month

WILC

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		- For State tegistrar		Certific	cate of l	Death			Reg. No.	000 24	00			
Physician		1. Decedent's Name (First, Midd	irst, Middle,Last) 2. Date of Death											
Medical Examin	er	Clifford H	Earl Fo	oster				July 13, 2	Day Year 2008	f 1704 hrs				
		4a. Facility Name (if not institution	n, give street and	number)	4t	. City, Town, or 1	ocation of D	eath	4c. County o	of Death				
		7689 Melvin Road				Denton		of a	Caroline					
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Year	If Under 2	4Hrs. 8. Date of E	irth (MM/DD/YYYY	th(MM/DD/YYYY) 9. Birthplace (State or				
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		Usual Residence of Decedent	1/25/11 21		110.		<u> </u>		23,2520	7 4 4 4 4				
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rylan a-fs	용ト	10e. Street and Number	JEETIC	1 000		10f. Zip Code	-		10g. Citizen of Wh	nat Country?				
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21. Men mar		19a. Informant's Name/Relations		11	9b. Mailing	Address (Stree				n, State, Zip Code)				
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nt of t: If	- 1	1 X Burial 2 Crematio		Unda	atory or othe	am. Cen	,	19 2008	King	- City or Town, State George, Va	,			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	H	4 Donation 5 Other S	pecify:	India		ame and Address								
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8760, ifficate be ng physic	틝	IF FEMALE: 23b. Was decedent pregnant in t		s, outcome of pregnance e birth		aldeath 3	Ectopic p	regnancy	23d. Date of Month	r delivery Day Year	ar I			
x 6	<u>S</u>	past 12 months?	4 Pre	egnant at time of death		er (Specify)								
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Records, P.O. Box 6i The law requires that the death cert cate has been signed by the attendir page 2 should be detached for use a	d b							1)	'es 2 ✔ No 3	Probably 4 Unkn	nown			
Vital Records ysician: The law requi his certificate has been:	Completed							24a. Wa		Were autopsy findings ava				
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Division of Vital Records, P.O. on a National Processing or Attending Physician: The law requires that the ours after death. Ireal Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.	Certification:		lid not be	lace of Injury - At home	, iaim, siree	t, ractory, office b	ullaing, etc.		, State) Road, Denton,	per or Rural Route Number	r, City			
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Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	ह	(Check only Certifying r		best of my knowledge, on the contract of the c										
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		mull a	1	M	D	O.C.	vi.⊏.		July 14, 20	700				
22		30. Name and address of perso					D - !!!	- MD 0400:						
DB 1831		Russell Alexander MI		Medical Examine	er 111	Penn Street,	Baltimor	e, MD 21201		 				
Sta		31. Date filed (Month, Day, Year,		Prigistrar's Signature	1.	de								
Registi	rar	1111 1	7 2008	Closur St.	1400				OCME					

			, FOI	partment of Health and N <i>ertificate of Death</i>		0000	01.600
	_	_	Registrar 1. Decedent's Name (First, Middle, Last)	erillicate of Death	Reg.	. No. 2008	3. Time of Death
	Physicia		Therese Irma Fillion		Month July 11	Day Year 2008	10:08 A ^M
ware.	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	10.00 A
			Anne Arundel Medical Center	Annapolis		Anne Aruno	lel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Coui	
	Director		Usual Residence of Decedent		Aug. 29,	1916 Rhod	le Island
	yland how		10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits
	e Ma 8a-f s	Director	Maryland Anne Arundel Crofton				1X Yes 2 □ No
	with th		10e. Street and Number	10f. Zip Code		. Citizen of What Cour	itry?
	eath ns 23	Funeral	1666 Carlyle Drive Apt. C 11. Marital Status 12. Was Decedent Ever in U.S. 1	21114 3. Was Decedent of Hispanic Origin? (Sp	Decify Yes or No-	A 14. Race - Americ	can Indian.
36	S should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinational be notified at	by Fun	Armed Forces? 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 No Specify:	Rican, etc.)	Black, White, Specify: Whi	etc.
2	72 hou	Completed		cedent's Usual Occupation		b. Kind of Business/In	
2	ithin 7	mple	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)			
2	iled w Hygiei ther ti	S	12 Mana 17. Father's Name (First, Middle, Last)		Fu e (First, Middle, Mai	rniture Of	fice
Maryland 21215-0036	d be f ental ced of c eve	To Be	Elphege Allaire	Marie Lo		con camamo,	
ary	shoul and M s marl umatl	ř		ailing Address (Street and Number or Rur		City or Town, State, Zip	Code)
Σ	and 2 ealth a n 27 is			Shaftsbury Avenue	Crofton,	MD 21114	
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Discemblery Company 1	rematory or other place)		c. Location - City or To	
Ħ	artmer ortant: Injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	netery 7/15 22. Name and Address of Facility Ro	/2008 Cr	ownsville,	MD
Ba	Depri Impo		10	16000 Annapolis Roa			al nome
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
f	Physician		Immediate Cause (Final disease or condition	rillation			Onset and Death
r	/Medical Examiner		Due to (or as a consequence of):			1	- (
		er	Sequentially list conditions, if any, leading to finite distributions to consequence of the consequence of t	ces			years
	cuted nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	nslar		1/	ncek
8760,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):				• ,
687	ficate I physk	dical	d				
Box (The law requires that the death certificate has been signed by the attending page 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the part 12 prothe? 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of deliv	ery
0.0	e deat the att	sicia		5 Other (specify)		Month	Day Year
σ.	w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to t	ne cause of death?
Records,	quires n sign ald be	d by			1 ☐ Yes	2 1 No 3 Prol	oably 4 🗆 Unknown
000	e faw rec has bee je 2 shou	Completed			24a. Was an	24b. Were auto	ppsy findings available impletion of cause of
	sician: The certificate hi rector, page	Com			autopsy performed 1 □ Yes 2 □	d? death? 1 ☐ Yes	
Ĭ;a	iclan: The certificate ector, pag	Be	25. Was case referred to medical examiner?	Othor	th (Check only one)		
0	Phys rthis ral dir	<u>2</u>	1 Yes 2 No		ome 5 Residence 28d. Describe how	ce 6 Other (Special	y)
on	nding tth. :: Afte e fune	atior	1 ☑ Natural 5 ☐ Pending (Month, Ďay, Year) Injur 2 ☐ Accident investigation	e of 28c. Injury at y Work? M 1 □ Yes 2 □ No		,,	
Division of Vital	i or Attending Phatter death. Director: After the in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	Il Route Number,
ō	oital o urs aft eral Di					/-\	-1-4
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, pages.	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de (Check only one) 2 Medical Examiner: On the basis of examination and/o and manner stated.				
	To th withir To th comp	∕Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month,	Day, Year)
	a orbi	\mathcal{Y}_{0}	I du Dea J. O.	H005809-	7 1	uly B,	2008
	·S		30. Name and address of person who completed cause of death (Item 23a) (Typ	ie, Print) C Hall An . a	e 100 E	20	201/121
	Sta	te	31. Date filed (Month, Day, Year) 32. Degistrar's Signature	o how the. or	1,00	Mapall	MAIN
	Registr	ar	JUL 1 6 2008 Bleeve &	park			
DI	NAUL 47 Day 4/0	004		,			

08-0	5348
Paul	Fitzgibbons

2008 24691 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2 Date of Death I. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ July 12, 2008 Medical Examiner 1120 hrs Paul Eugene Fitzgibbons 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1258 Shaeffersville Road Mount Airv Howard If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign DISTrict 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** oreign Days Months Hours Min Director Country) of Columbia 2 F 1 X M 1962 220-58-6799 46 11 June Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No 28a-f show imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene, and it. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. Maryland Howard Mount Airy Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 1258 Shaffersvill Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 2 X No Yes Specify: White 3 Widowed If Yes, Give Year 1 Yes 2 X No specify: 4 Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Sales Executive Printing 18.Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eugene Garges Fitzgibbons Patricia Margaret Flanagan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise M. Fitzgibbons, wife 1258 Shaffersville Road, Mount Airy, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, Important: If crematory or other place) Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 7/18/2008 Alexandria, Virginia Donation 5 Other Specify: 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature of Funeral Service Licenses 26401 Ridge Road, Damascus, Maryland 20872 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and failure. List only one cause on each line. /Medical Death a Contact Shotgun Wound to Chest Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED the attending physician ed for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? چ 1 Yes 2 V No 3 Probably 4 Unknown Completed ficate has been si page 2 should b 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? death? Yes Yes 2 V No 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director; it 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other; DOA Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot self 1 FOUND: Natural Pending 1 Yes 2 ✔ No Jul 12, 2008 1100 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be or Town, State) 1258 Shaeffersville, Mount Airy, MD To the Funeral 4 (Specify) Back of pickup truck Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner on the Vasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. July 13, 2008 30. Name and address of who completed cause of death (Item 23a) **OCME** Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

			For State Registrar	State o	f Marylan		artment <i>rtificate</i>			and M		jiene leg. No. 2 (800	24692	
	Physici	an	1. Decedent's Name (First, Middle, La	st)					_		Date of Dea Month	Day	Year	3. Time of Death	
*	/Medic	-	Earl Howard Geor	_							Ju1y		2008	1:20 A. ^M	
	Examin	er	4a. Facility Name (If not institution, giv		mber)		4b. City, To			of Death		4c. County of Death Garrett			
			1325 Bittinger R 5. Social Security Number 6. S		7. Age (In yrs.	last birthdav)	If Under 1	anto Year	If Under	24 Hrs.	8. Date of Birth	1		lace (State or Foreign	
	Funeral Director			X M 2□F	66	Yrs.	Months	Days	Hours	Min.	June 8	, Year)	Coun	yland	
	p		Usual Residence of Decedent												
	arylar show d at	_	10a. State 10b. County			y, Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	he Ma-f	Director	MD Garrett		S	wanton	_	2-4-				10a Citizan of	What Coun	**	
	a or a		10e. Street and Number	1			10f. Zip 0	.561				10g. Citizen of United		-	
	eath	Funeral	1325 Bittinger R	T .	edent Ever in U.	S. 13.				igin? (Spe	ecify Yes or No-		ce - Americ		
_	r Iten	핊	1 Never Married Married	Armed Fo	orces? 2 V 1 No	ì		_			ecify Yes or No- Rican, etc.)	Bla	ick, White,	etc.	
3	ral", o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ve lates:		1∐Yes 2M	No No	Specify:			Speci	whi	te	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usual kind of work DO NOT use	Occupa done o	ation during mos	t of work	ng I	16b. Kind of E	Business/Ind	dustry	
7	/ithin ne. han " e Mei	du	Elementary/Secondary (0-12)	College (1-4or 5+)							Real E	atata		
7	iled w Hygie ther t	ပ္ပ	12 17. Father's Name (<i>First, Middle, Lasi</i>	*)		Real	ator 8	X DI		er's Name	(First, Middle,				
and	d be f ental I ed of	Be C	Ellwood George	/				İ		a Eva					
<u></u>	should nd Me mark matk	ဠ	19a. Informant's Name/Relationship	Type. Print)		19b. Mailir	ng Address (Street a			al Route Numbe	er, City or Town	, State, Zip	Code)	
	nd 2 alth al		Carolyn George,	Wife		1325	Bitti	inge	r Rd	., St	vanton,	MD 215	61		
ē,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		20b. F	Place of Dispo					Date	20c. Location		own, State	
E	Pages nent of I ant: If Ite ary or o	W	1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (<i>Speci</i>		State	rett M				ns 7,	/22/08	0ak1a	nd, M	D	
Baltimore,	permit. Pag Department Important: It any Injury o		21. Signature of Funeral Service Lice	nsee		22	2. Name and Davio	Addres	ss of Facili	dock	Funeral	L Home,	P.A.	1/-	
m	9 9 5 6 9		Katherine	Sweis	54		21 N.	Se	cond	St.	, Oaklar	nd, MD	21550		
8760,	Physician holding by second by secon	dical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	las	uence of):	ibre	5,0	Luni	nd	Trasf	0515	C	Interval Between Onset and Death WELLS MC - Lub yea YEUS	
O. Box 6	ath certif ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live	itcome pf pregna birth 2 Feta nant at time of d	uldeath 3∐	⊒Ectopic pre ⊒ Other <i>(spe</i>		,				ate of delive	ery Day Year	
rds, P.	quires that the de n signed by the a lld be detached f	by	Part II. Other significant conditions	contributing to c	leath but not res	ulting in the u	nderlying cau	use give	en in Part		23e. Did to		ntribute to ti 3 Prot	ne cause of death?	
Records,		Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No									mpletion of cause of			
Vital	clan: sertific setor,	Be (25. Was case referred to medical examiner?	Hoopital				041-	-	e of Deat	(Check only o				
0	Physi this c	은	1 ☐ Yes 2 ☑ No 27. Manner of Death		Inpatient 2	ER/Outpatier 28b. Time o			4 ∐ N	ursing Ho		lence 6 🗆 O		y)	
2	aling F I. After funer	ion:	1X Natural 5 Pending		nth, Day Year)	Injury	M 28	Bc. Injury Work	yat k? Yes 2 □		28d. Describe h	iow injury occi	irrea		
Division or	I or Attending Physician: after death. Director: After this certification by the funeral director, I	Certification:	2	e 28e. Plac	e of injury - At ho ling, etc. (Specif	ome, farm, st (y)			103 2	140	28f. Location (S City or Ton		ber or Rura	al Route Number,	
	Hospita 24 hours Funeral	Medical Co	29a. Certifier 1 Certifying P (Check only one) 2 Medical Example 1	miner: On the I	e best of my kno basis of examina oner stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the tin in my o	ne, date a pinion, de	nd place, ath occur	and due to the red at the time,	cause(s) and r	nanner as s e, and due to	tated. the cause(s)	
	To the within To the Comple	Me	29b. Signature and title of certifier			N	29c.	Licens	e number			29d. Date sign	ed (Month,	Day, Year)	
		2	111An.	\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	M	1		1)	47	925		9/2	1/08		
•		3	30. Name and address of person who	completed cau	se of death (Iten	n 23a) (Type,	Print)	1	1	10	\ (1	1 1	1	1 \ Anie	
		5	C	Nortec	Hi	Werl	1/2	M	1.	31	North all	Litre	ork	Jun Mario.	
	Sta Regist		31. Date filed (Month, Day, Year) JUL 2 1	2008	Agistrar's Signa	ature	Special)							

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	Physici	an	Decedent's Name (First, Middle, La	,						Date of De Month	Da		3. Time of Death	
	/Medic	al	ANNA JUNE 4a. Facility Name (If not institution, giv	GROVE			4b. City, Town, or	Location of I		JULY :		2008 County of Deal	8:15 P	101
3	Examir	er	FROSTBURG VILLAG	,	IOME		FROSTB		Dealli			ALLEGAN		
-	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last	birthday)	If Under 1 Year	If Under 24	Hrs. 8.	Date of Bir	th	9. Birt	hplace (State or Fore	ign
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	yland now at		10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Inside City Lim	
	a-fst	ctor	MD ALLEGAN	Y	WESTE	RNPO	RT						1.X Yes 2□	Vo
	or 28)ire	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of What Co	untry?	
	23a ust b	ral	209 POPLAR STRE	ET			2156					USA		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2፟፟፟ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ∑ No	ispanic Origir an, Mexican, i Specify:	n? (Specify Puerto Rica	Yes or No an, etc.))-	14. Race - Ame Black, White Specify:		
5-0	72 hc 'natu dical	etec	15. Decedent's E	ducation ade completed)	10	6a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most o	f working		16b. k	(ind of Business/	Industry	
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anc	l be fi	Be	WILLIAM DEWEY						EL MI			i Sumamej		
Ž	should ind Men marker umatic	မ	19a. Informant's Name/Relationship (1	9h Mailir	ng Address (Street	-				or Town State	Zin Code)	
Maryland	id 2 sho Ith and 27 Is ma traum		EARL GROVE / HUSI				POPLAR ST							
	s 1 and 2 of Health litem 27 other tra		20a. Method of Disposition	52111D	20b. Place	of Dispo	sition (Name of natory or other place		Date			ocation - City or		
Baltimore,	t. Page rtment o rtant: If njury or		1 N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	(y)	1	VIEV	CEMETER	Y 07	/23/2	8008	BAR	TON, MD		
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	uires tha signed b	by	Part II. Other significant conditions	contributing to death bu	it not resultin	g in the u	nderlying cause give	en in Part I.					the cause of death?	
I Records,		Completed							- [24a. Was auto perfe 1∐ Yes		prior to	rtopsy findings availa completion of cause of	ble of
Vital	Physiclan; this certificatal director,	Be (25. Was case referred to medical examiner?	11			T.	26. Place o	f Death (C		-	-		_
or	shysi this o	P	1 Yes 2 PhNo	Hospital:				4 LAUNUIS				6 ☐Other (Spe	cify)	
n	ding Ph J. After th funeral	ü	27. Manner of Death 1 → Natural 5 Pending	28a. Date of Injur (Month, Day		b. Time o Injury	Wor			. Describe	how inju	ary occurred		
Division	death death ctor: y the	Certification:	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 290 Place of inju	ry - At home :. (Specify)	, farm, str	M 1 □ reet, factory, office	Yes 2 □ No		Location (City or To			ıral Route Number,	
1	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination	dge, deat and/or in	h occurred at the tirvestigation, in my o	me, date and opinion, death	place, and	due to the	cause(:	s) and manner as nd place, and due	s stated. e to the cause(s)	
	o the	Mec	29b. Signature and title of certifier	and manner sta			29c. Licens	e number			29d. Da	ate signed (Mont	h, Day, Year)	_
	⊢ ≼ ⊢ ŏ			Thelm			1) 2	6907	,			y 22		
		2	30. Name and address of person who		eath (Item 23	a) (Type.		-101			<i>y</i> - '	1	0	_
		2	DR. HARJIT SI	· ·			•	UMBERL	AND,	MD 2	2150	2		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature		Lange o							

Thomas Irving Gross, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 24694

		Registrar Certificate of	Death		g. No.								
Physicia Iedical Examir		1. Decedent's Name (First, Middle,Last) Thomas Irving Gross, Jr.		2. Date of Deat Month July 18, 20	Day Year	3. Time of Death 2207 hrs							
)		4a. Facility Name (if not institution, give street and number) University Hospital	4b. City. Town, or Location of Death Baltimore		4c. County of Death								
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 217-60-6081 1 X M 2 F 53 Yrs	If Under 1 Year If Under 24Hrs Months Days Hours Min	Decemb		hplace (State or Foreign untry) ryland							
5-0036 led within 72 hours after death with a tygiene. Tygiene "matural", or items 23, other than "natural", the Medical Examiner must be not	Be Completed by Funeral Director	1 X Never Married 2 Married 3 Widowed 4 Divorced of Pres, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Piney Point 10f. Zip Code 20674 s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto Yes 2 No specify: It's Usual Occupation (Give kind of vost of working life. DO NOT use retiremence Painter 18. Mother's Name	pecify Yes or No- Rican, etc.) work done	White, etc. Specify: B1a 16b. Kind of Business/I Public Scho Maiden Surname)	can Indian, Black, ack							
Baltimore, MD 2121 permit Pages I and 2 should be fi Department of Health and Mental I important: If item 27 is marked injury or other traumatic event,	1	19a. Informant's Name/Relationship (Type, Print) Geraldine Gross / Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Cable Hollow Way Upper Marlboro, MD 20774 20a. Method of Disposition 20a. Method of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mark's UAME Cemetery 2008 20c. Location - City or Town, State Valley Lee, Maryland											
		21. Signature of Funeral Service Liconsee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home. P.A. P.O. Box 270 Leonardtown, MD 20650											
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries Approximate Interval Between Onset and Death											
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions,											
	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Ursease or injury that injuried											
ecuted and - transit		events resulting in death) Last Due to (or as a consequence of): d.			-								
8760, rificate be executed ng physician and as the burnal - transi	n/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliver	v							
	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fearnant at time of death	tal death 3 Ectopic pregna her (Specify)	ancy		Day Year							
rds, P.O. B requires that the d been signed by the hould be detached	<u>≥</u>	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	1 Yes	obacco use contribute to	pably 4 Unknown							
Reco The law ficate has	Completed	25 Wes sees when the market		1 ✔ Yes	esy prior to or rmed? death?	otopsy findings available completion of cause of ses 2 No							
Vital hysician:	Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other:											
ion of V ttending Phy death. ttor: After th	ation: To	27 Nearest Death											
Division pital or Attendio ours after death. filted in by the f.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street (Specify) Major Rpad / Highway			Street and Number or Ru state) Notch Road, Hollywoo								
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occur one) Medical Examiner: On the basis of examination and/or investigat and manner stated.	tion, in my opinion, death occurred a		and place, and due to th	e cause(s)							
		29b. Signature and title of certifier Aurer Court	29c. License number O.C.M.E.		29d. Date signed (Mo July 19, 2008	nth, Day,Year)							
			Street, Baltimore, MD 212	201									
Sta Regist	_	31. Date filed (Month, Day, Year) JUL 2 2 2009 32. Registrar's Signature	0										
DHMH 17 Rev 1/20	01	OCME ORIGINA	L										

amend line 17 per fd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 07/16/08 dlwState of Maryland / Department of Health and Mental Hygiene 2008 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2008 Patricia Gillis July 10, 11:45 P™ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Linthicum Tate Hospice House Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 5, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1 □ M 2X F Months Hours 53 Oct. Director 216-64-2141 1954 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location d 2 should be filed within 72 hours after death with the Marylar thit and Mertal Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Exprince must be notified as 10d. Inside City Limits Director 1X Yes 2 □ No Prince George's Maryland Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12745 Midwood Lane 20715 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No þ 3 ☐ Widowed 4 🏋 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Personal Bank Representative Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 is marked otl Charles E. Menges Mabel M. Bloom Charles C. Menges 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i 7968 Bolling Drive Alexandria, VA 22308 James E. Menges/ Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/12/2008 Alexandria, VA Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) STCI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Je. Due to (or as a consequence of) Examir The law requires that the death certificate be executed burlal-transit end resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetai death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a o 9 ☐ Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ੬ been sl 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t irector, page 2 s 24a. Was an autopsy perform 2 DNO 1 ☐ Yes 2 P No 1 Tyes Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dether (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this Within 24 hours after uses...
To the Funeral Director: After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 40 455 31. Date filed (Month, Day, Year, **P**egistrar's Signature 1 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 14 2008 4:10 PM July Charlotte Ann Goldsmith /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll 415 Kingsbury Way Apt # 24 Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 3 1940 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 X F Yrs. 215-40-8288 68 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No **Funeral Director** Westminster MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Apt #24 21157 415 Kingsbury Way 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary London Foa 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Lillian Fischer Burnell Rosenberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Taneytown, MD 21787 Anne Hynson/daughter 1 Reaverton Ave 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 07/18/2008 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kriders Church Cemetery Westminster, MD 21. Sign Fundal Service Licen 27171115 Tune and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmono--mostism /Medical Due to (or as a consequence of): Examiner AN MSC Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner The law requires that the death certificate be executed physician and the burial-transit Houre Due to (or as a consequence of) Box 68760. as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 DNo Month Day 5 Other (specify) Division or Vital Records, P.O. as been signed by the a 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 22 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate ha autopsy 2 ☐ No 1 ☐ Yes 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 251 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury Natural 2 Accident I Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a Hospital Certifying Physician: To the best of my knewledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of gramination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) gation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 29c. License number 037949

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed ca

JUL 1

Year)
1 7

31. Date filed (Month, Day,

2 hours heme

(Type, Print)

ath (Item 26a)

use of d

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Martin Joseph Gramlich, Sr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours **1** M 2 □ F 79 173-22-7106 Director Apr 18 1929 PA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits a or 28a-f show t be notified at 28a-f show 1 ☐ Yes 2 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 210 Adeline Drive "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Londontown Mfg Purchasing Agent s 1 and 2 should be filed w of Health and Mental Hygiel item 27 Is marked other th other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Mae Holtz Harry B. Gramlich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trat once. Marilyn Gramlich/wife 210 Adeline Drive Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 07/19/2008 Westminster, MD Meadow Branch Cem 21. Signature of Funeral Service L 22Pritts Tunerall Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTION MYOCARDIAL ACUTE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s autopsy perform certificate 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No After this c Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the h within 24 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30263

31. Date filed (Month, Day, Year) Registrar

FRANCIS KHOO.

2008

32. Registrar's Signature back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, MD ZOO MEMORIAL AVE, WESTMINSTER, MD

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day July Ruth Headlee 2008 15, 6:30A. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hillhaven Assisted Lvg. Nursing & Rehab Ctr. Prince George's Adelphi | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 17, 1914 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday, 220-26-4865 1 □ M 2 1 F 93 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Bowi.e 1 XYes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4802 Silverbrook Wav 20720 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify. Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arvel C. Kiger Goldie Renner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6100 West Chester Park Drive,#1413 College Park, Maryland 20740 Joseph Philip Headlee -son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State George Washington Cemetery 7/19/2008 Adelphi, Maryland 4 □ Donation 5 □ Other (Specify) Donald V. Borgwardt Funeral Home, PA 21. Signature of Funeral Service Licenses Donald 01 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheimer's Disease disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coronary Artery Disease; Hypertension; Hyperlipidemia 2 No 3 Probably 4 □Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 【XNo 24a. Was an performed? Yes 2 X No examiner 1 ☐ Inpatient 2 ER/Outpatient 3 DOA

requires that the death certificate be executed burial-tran P.O. Box 68760, physician the as nding p nse i atter for u ed by the a s been signed by the should be detached Division or Vital Records, has le 2 page certificate or Attending Physician: this After thi funeral

Hospital

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10 0 Physician/Medical ş Completed Be 2 Certification: Medical

Examiner

Physician

/Medical

Examiner

Funeral

Director

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Department of Important: If any injury or once.

Physician

/Medical

Examiner

Director

Funeral

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Completed

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

25. Was case referred to medical 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 5 Pending investigation Injury 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, offic building, etc. (Specify) 4 ☐ Homicide

		_		•
26. Place of Dea	th (Check only one)			
OA Other: Nursing H	ome 5 ☐ Residen	e 6	☐Other (Specify)	
28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how			
ry, office	28f. Location (Stre City or Town,	et and State)	Number or Rural Ro	ute Number,

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

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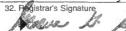
D55559 July 16, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Thomas E. Maslen, M.D. 7525 Greenway Center Drive, #316 Greenbelt, Maryland 20770 31. Date filed (Month, I

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 24699 1- State Amend Item 1 per phys. 881 7 Cordinate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Randy 5:14 AM Millard Randolph Hess, Jr. 2008 21 July /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner of Maryland Medical Center University Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**∑**M 2□F Months Days Pennsylvania May 29, 1961 Director 168-52-2566 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Its Medical Examinations and injury or other traumatic event, Its Medical Examinations. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 🛛 No Director Ceci1 E1kton Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 2320 Blue Ball Road, Apartment B 21921 Funeral 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor Assisted Living 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Millard Randolph Hess, Sr. Jean Pierce 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 896 Mountaindale Road, Vilas, NC 28692 Millard R. Hess, Sr./Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date July 2008 25, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sharps Cemetery Fair Hill, MD ^{22, Name and Address of Facility}
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21. Signiture of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hemolytic Anemia **Physician** /Medical Due to (or as a conse luence of): **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and I-tran Due to (or as a consequence of): attending physician a for use as the burlal-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' certificate 1 ☐ Yes 2 D No 2 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State

Registrar

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30. Name and address of person who completed cause of death (item 23a) (Type, Print)

2008

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32. Registfar's Signature

Blocher

eann Silhan

Year)

JUL 3 1

31. Date filed (Month, Day,

17466

Street Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July **Physician** Day Corena I. Hawkins 2008 2008 11:45AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center Months Days Hours Min. 3 a n 2 4 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ XF 84 Yrs. 216-18-5536 1924 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or Items 23a or 28a-f show the Madical Experience must be notified at 1 Yes 2 No Maryland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 USA 12 Dorsey Ave death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Madical Exerci Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 2 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Families 11th Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jannie Butler Joseph Smith ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12 Dorsev Ave Annapolis, Md. 21401 Victoria E. Johnson(Daughter) 20c. Location - City or Town, State Date 20a. Method of Disposition 20b-Place of Disposition (Name of Dismeter), cromatory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-17-08 Memorial Park Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Williame RAS of Gacilia ous Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 MO 083 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 15rilletic may 415 ttria /Medical Due to (or as a conse vence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner as a consequence of) dec wed a The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year signed by the a 5 Other (specify) 1 ☐ Yes 2 MNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ate has autopsy performed certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ANO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 a Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural

Hospital or Attending Physician: funeral director. After nours after death.
neral Director: Aft
y filled in by the fun

5 Pending investigation

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifie

Dr. Musiree

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

and manner stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Center #1 Crofton, mal 21114

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0040519

29c. License number

29d. Date signed (Month, Day, Year) 7.10.08

State Registrar

Medical

31. Date filed (Month, Day, Year) 1 6 2008



To the Hospital of within 24 hours a To the Funeral D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** July 14 2008 <u>Robert H. Havgood Sr.</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Annapolis Anne Arundel Medical Anne Arundel Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Jan. 29 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Year 925 1**X** M 2□ F Alabama 260-24-0365 82 Yrs Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar must be notified at Director Maryland Anne Arundel Annapolis 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3425 Rockway Ave 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \ Xes 2 □ No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No þ Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns any Injury or other traumatic event, In a Modis once. (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Elementary/Secondary (0-12) 12th College (1-4or 5+) Industrial Art's Teacher Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Haygood Vernetta Tyrus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3425 Rockway Ave Annapolis, Md. 21403 Emily L. Haygood (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran 20a. Method of Disposition Date 20c. Location - City or Town, State 1 D Burial 2 ☐ Cremation 3 ☐ Removal from State 7-21-08 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Minume Reaches of Scilis ons Mortuary, 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Farry 100783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. the detached 9 Unknown ρ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ð 20 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe this certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 1 Shipatient 2 ER/Outpatient 3 DOA ၉ After thi funeral 27. Manner of Death Certification: 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after on Funeral Direct 4 Homicide 29a. Certifier 1 Prifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one)

Registrar

29b. Signature and title of certifier

30. Name and address of person

and manner stated.

ho completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

	`		For State Registrar	State of	Maryland /	Departme <i>Certifica</i>			nd Mental Hy		008 2	4702	
	Physici		Decedent's Name (First, Middle, La James Basore	_					2. Date of De. Month July		Year 3. Tir	me of Death 5 A. M	
ر	/Medio Examir			the (If not institution, give street and number) 4b. City, Town, or Location of Death 4ctherine's Nursing Center Emmitsburg									
	Funeral Director		209-12-6979	Sex 1 ∑ M 2□F	. Age (In yrs. last bi	Yrs. If Und Month		If Under 24 Hours	Hrs. 8. Date of Birl Min. (Month, Da Dec.12,	y, Year)	9. Birthplace (S Country) Pennsy1	tate or Foreign V ania	
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Maryland 21215-0036	within 72 ho ene. then "natur the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-	16a	16b. Kind of E	Business/Industry						
land 2	uld be filed Mental Hygi irked other	To Be Co	7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Katie Brindle										
	end 2 sho ealth and N n 27 ie me	. STATE OF	19a. Informant's Name/Relationship J.B. Heefner (So.	•	3.	323 Lin	boro	Rd. M	or Rural Route Number anchester,				
Baltimore,	: Pages 1 tment of He tant: If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the Content	<i>fy)</i>		of Disposition (A Pry Crematory of Chull Ch ren Cem	oby place etery	1 2	uly 29, 2008	Smith	- City or Town, Sta		
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د	Physician /Medical Examiner	J.	23a. Part1. Enter the disease, or con shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	aDue to (o	used the death. Do ch line. r as a consequence	d al	ode of dying	g, such as cal	Demen	-	Interva	ximate al Between nd Death	
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ords, P.	w requires that the de i been signed by the e should be deteched f	þ	Part II. Other significant conditions	contributing to dea	ath but not resulting	in the underlying	cause give	n in Part I.	23e. Did to	~	ntribute to the caus		
Division of Vital Records,		Completed	25. Was assa safarad to madical	e Heo	mt la	ulun			1 ☐ Yes	nped? 2 No	Were autopsy find prior to completion death? 1 Yes 2 VNc	n of cause of	
Ž	× 5	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		patient 2 ER/O	utpatient 3	OOA Other		Death <i>(Check only o</i>		her (Specify)		
islon o	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certificompletely filled in by the funeral director.	ertification;	27. Manner of D ath 1 Natural 5 Pending 2 Accident investigator 3 Suicide 6 Could not I	on Diagonal		Time of Injury M		at (? ′es 2 ⊡No			rred aber or Rural Route	Alumba	
<u>≥</u>	oitef or A urs after erel Direc	O	4 Homicide determined	building	g, etc. (Specify)				City or Tov	vn, State)		Namber,	
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	(Check only 2 Medical Exa	miner: On the bas and manne	is of examination at	nd/or investigati	on, in my opi	inion, death	place, and due to the occurred at the time,	date and place	, and due to the ca		
P	Witt To		29b. Signature and title of certifier	1	aud	m	9c. License	187C	5	7 2	ed (Month, Day, Ye	ear)	
			30. Name and address of person who Alan Carroll M. 31. Date filed (Month, Day, Year)	D. P.O B	of death (Item 23a) OX 308 Em	mitsbur	g,Mđ.	21727					
DH	Sta Registr	ar	JUL 3 1 2	008	yes A	Spendle	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Items 25,27,28a-f per me 9822,08/15/08dhb Registrad 25,per M.E., 7/21/08, BA Certificate of Death WCHD Reg. No. 2 Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Joseph Thelma 2008 4:50 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Atlantic General Hospital Berlin Worcester 8. Date of Birth Month, Day, Year 5/15/1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 163-05-6392 90 PA Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Funeral Director Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30 Harlan Trace 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 X No Specify: If Yes, Give Year or Dates: Completed by white 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health Care Dietician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emily Frank John Wagner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith C. Short 30 Harlan Trace, Ocean Pines, MD 21811 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If it any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/19/2008 Galloway, NJ 4 Donation 5 Domer (Specify) encombment Germania Cemetery 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. P. of 1. Enter the sease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause open line. Approximate Interval Between Onset and Death Immediate Cause (Final Fibrillation atrial **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, fracture pelvic 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown de montia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 🗷 No 1 ☐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1⊟ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To ō 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month. Day, Year) 28d. Describe how injury occurred al or Attending F after death. I Director: After 5 Pending investigation 1 Natural 2 A Accident 07/16/2008 1 ☐ Yes 2 X No Subject fell. Unknown 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1135 Ocean Pkwy. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Assisted Living Facility Berlin, MD 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. Age. License number Dology 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00062130 2008 30. Name and address s of person who completed cause of death (Item 23a) (Type, Print) Healthung Dr. Berlin, MN Anoia, M.D. BAG 9733 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 1 2008 Registrar

DHMH 17 Rev 1/2001

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8-05677 lames Thomas Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 24704

			For State	, , , , , , , , , , , , , , , , , , ,	Certi	ificate o	f Death					Reg. No		. 0 0		10
Physi	cian/		Decedent's Name (First, Middle,Last)								Date of De Month		Year		Time of Death	
lical Exa		ì	James Thomas Jon								Month July 24,		la Caustu at	Death	1254 1115	-
		48	a. Facility Name (if not institution, give s	treet and number)			4b. City, Tov Waldor		ocation of E	Death		l l	lc. County of Charles	Death		
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Funer			Social Security Number 6. Sex			t birthday)	If Under Months	Days	Hours	Min.			1971	C ~	4-m ()	
Directo	or	L	216-11-5405 1XM	1 2 F	37	Yn	S.				ounc		17/1	rial	yland	_
*		_	sual Residence of Decedent 0a. State 10b. County	- I	10c City, T	own or Loca	ition					-		1	10d. Inside City Limi	its
¥ 30		1	,					T.T.o.	ldorf	=				- 1	1 Yes 2 X	No
/land -f she	once to		Maryland Charle Oe. Street and Number	5			10f. Zip C		Idori			10g. C	itizen of Wh	at Count	ry?	-
Mary r 28a	Director	,		-					602					TICA		
death with the Maryland or items 23a or 28a-f show any			3952 Old Washingt	on Road	Ever in 11 S	13 W	as Decedent			? (Spe	cify Yes or	No-	14. Race	USA - Americ	an Indian, Black,	\dashv
tems	Funeral		Married 2 Married	Armed Forces?		lf.	Yes, specify	Cuban,	Mexican, F	Puerto R	tican, etc.)		White	, etc.		
er de			3 Widowed 4 Divorced	1 Yes 2 Yes, Give Year	X No	1	Yes 2	X No	specify:				Specify:	Whi	te	
ırs aft Iural'	Examiner fed by	٦-	15. Decedent's Education (Specify only	or Dates:	pleted)	16a. Decede	ent's Usual O	ccupati	on (Give kir	nd of wo	rk done	16b	. Kind of Bu	siness/In	dustry	
2 hou	he Medical Exar	1	Elementary/Secondary (0-12)	College (1-4 or 5	i+)		most of work Mechai		DO NOT US	se retire	(a)		Self E	mn1a	ved	
thin 7	ledica		12			Auto	меспа							•	yeu	
5-0 ed wi tygie other	1 E		17. Father's Name (First, Middle, Last)					1					en Surname			
21215-0036 suld be filed within 7 Mental Hygiene.	event, the Medical	3	James Leon Jones			Lagr. Marin	ng Address				_		/alden		Zin Code)	
20 Should and Ma	afic e	2 1	19a. Informant's Name/Relationship (Typ Sandra Virginia Je		ther	1	Old V							206		-
MI alth a	raum	-	20a. Method of Disposition			3	osition (Nam			11 10	Date		c. Location			\neg
of He	or other traumatic	- 1	1 X Burial 2 Cremation 3	Removal from Sta	ate c	rematory or	other place)			July	29,	-	11		M 1 1	
Pag ment	or 01	Ļ	4 Donation 5 Other Specify:	1	Cha		morial Name and				2008	L	eonardt	own,	Maryland	\dashv
Baltimore, MD 21215-0036 permit; Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-5 sho	injury	1	21. Signature of Funeral Service Ucons	e y dis	101)	22	Mattin	gley	-Gardin	ner F	uneral	Home	e, P.A. 0650			- 1
		+	23a. Part I. Enter the disease, or compli	cations that caused	the death.	Do not ente	r the mode o	f dying,	such as ca	rdiac or	respiratory	arrest,	shock, or he	art	Approximate Inter	
Physici Medic		ı	failure. List only one cause on eac	h line. Hypertens :											Between Onset a Death	and
.amir				ue to (or as a cons			creroc	10 0	cardi	UVas	Culai	<u> </u>	Sease_			一
			Sequentially list conditions, b													
			if any, leading to immediate Cause. Enter Underlying Cause	ue to (or as a cons	equence of	f):					•					
	nsit		(Discoss or injury that initiated C.	Oue to (or as a cons	equence o	f):										
inted	ansit		d.													
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed at hours after death.	the burial - transit	Medical	X UNPENDED	AMENDED 23	a,27,	perME	, g882	8/	11/08	TT						
760, icate be	e bur	e l	IF FEMALE:	23c. If yes, outco	me of preg	nancy							23d. Date o			
687 Sertific	as th		23b. Was decedent pregnant in the past 12 months?	1 Live birth	timo of da	oth -	Fetal death		Ectopic	pregna	ncy		Month		Day Year	1
Box (e death of	for use as th	sician	1 Yes 2 No 9 Unknown	4 Pregnant a	time or de	5	Other (Spec	city)				-				
the de	ached f	≥1	Part II. Other significant conditions		th but not r	esulting in th	e underlying	cause	given in Pa	rt I.	23e. [Did toba	cco use con	tribute to	the cause of death?	?
P,O	dets	2									1	Yes	2 No 3	Pro	bably 4 🗸 Unknow	wn
ds,	should be	Completed										Vas an	24b.	Were au	utopsy findings avail completion of cause	lable
SOF law re	2 2	힑									r	erforme		death?		
Re The	ector, page	ទី						26 Plac	e of Death	(Check		es 2	No	1 🗸 Y	es z No	
of Vital Records, ag Physician: The law require	rector	8	25. Was case referred to medical examiner?	lospital:	ent 2	ER/Outpati		OOA	Other ₄	_	ng Home 5	Re	esidence 6	✓ Othe	r: Scene	
Physics :		င္	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of In		28b. Time			ıry at Work				w injury occu	rred		
ding G	Atter	<u>e</u>	1 X Natural 5 Pending	(Month, Day,	Year)			1	Yes 2	No						
Sio Atten	by the	cat	2 Accident Investigation	28e Place of I	njury - At h	nome, farm, s	treet, factory	, office	building, et	tc.				ber or R	ural Route Number,	City
Division Hospital or Attendia 24 hours after death.	filled in	Certification	3 Suicide 6 Could not determine	pe							or To	wn, Stat	te)			
lospit 1 hour	uner:		29a. Certifier 1 Certifying Physici	an: To the best of r	ny knowled	dge, death or	ccurred at the	e time, o	date and pla	ace, and	due to the	cause(s) and mann	er as sta	ted.	
To the H	To the Funeral completely filled	edical	one) 2 Medical Examiner	:On the basis of ex	amination :	and/or invest	tigation, in m	y opinio	n, death oc	curred	at the time,	date an	d place, and	due to t	he cause(s)	
To	COL	Me	29b. Signature and title of certifier	and manner stated	1		29	c. Licen	ise number			1	29d. Date sig	gned (Me	onth, Day, Year)	
			106,11	1/1	-			O.C	.M.E.				July 25, 2	8009		
			30. Name and address of person who	completed cause of	de th (Iter	m 23a)										
				stant Medical E			enn Stre	et, Ba	Itimore,	MD 21	1201					
	Sta	ate	31. Date filed (Month, Day Year)	2008 32. Re	rar's Signa	ture	1.1	7				00	ME			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Chester Newman Jenkins 17 2008 2:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 205 E. Potomac St. Brunswick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5/3/1935 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 73 233-50-9984 Director WV Usual Besidence of Decedent permit. Pages 1 and 2 should be filed within 72 hours etter deeth with the Maryland Department of Health end Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23s or 28s-1 show eny injury or other traumatic event, the Madical Examiner must be neittined at 900s. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 No Director Frederick Brunswick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 E. Potomac St. 21716 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White à 3 ☐ Widowed 4- Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy Jenkins 2 Elizabeth Sweeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Carter, Companion 205 E. Potomac St. Brunswick MD 21716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 7/18/08 Hagerstown MD 21. Signature of Funeral Service Licenses,
Barbara A Williams 22. Name and Address of Facility John T Williams Funeral Home, Brunswick MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ocardia ischemic novve /Medical Due to (dr as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): attending physicien for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached t 2 No 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4. Unknown certificate has been si irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 46 B Die Freder 2-1+EGA 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 7:11 p M 2008 Richard Bruce Kyser Ju1v 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles 156 Morgans Ridge Road La Plata If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 18,1939 New York 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 ▼ M 2 □ F Director 68 October 124-30-0986 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director Maryland Charles La Plata 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20646 United States Funeral 156 Morgans Ridge Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates 1956-1958 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Demolition/Excavation Project Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel A. Howes Harry F. Kyser ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 156 Morgans Ridge Road La Plata, Maryland 20646 Candy K. Kyser/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Remova! from State July 17,200\$ Charlotte Hall Brinsfield-Echols 21. Signature of Fundral Service License 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. M01458 P.O. Box 567 211 St. Mary's Ave. La Plata, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List or young cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final netas **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? 1 □Yes 2 □ No certificate 1∐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2☐ Ño Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1-1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No death. after death. 2 Accident in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I completely filled Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) V 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 703 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 7 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 For

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it's Madical Exximetriant to rothfied at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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	•	for State Registrar	State of M	Marylan	d / Depa <i>Cer</i>	ırtmer <i>tificat</i>	nt of H te of E	ealth Death	and Me		giene Reg. No.	200	8	24707
hysicia		1. Decedent's Name (First, Middle Margaret G. Kl.								nate of Dea Month uly 15	Day	008 Ye	ar	3. Time of Death 7:25 A M
/Medic Examin		4a. Facility Name (If not institution Montgomery Gene	-			4b. City,	Town, or 01ne		of Death	-	4c.	County of E		omery
ineral ector		5. Social Security Number 217-34-4567	6. Sex 7 1 □ M 2 F	Age (In yrs. I	ast birthday) Yrs.	If Unde Months	r 1 Year Days	If Unde Hours	Min. N	B. Date of Birt (Month, Da ov. 18	h , Year) , 19	9.	Birthp Coun	olace (State or Foreign otry) Austria
28a-f show	ector	Usual Residence of Decedent 10a. State Maryland Mon	, Town or Lo			lver Spring 10d. Inside City Limits 1⊠Yes 2□No								
23a or 2	Funeral Director	10e. Street and Number	2 Tottenham	Terr.									S . A	
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinar must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ⅨWidowed 4 ☐ Divorced	nt Ever in U.! s? 2 \$No s:								Black, V	Vhite, e		
r than "natu Itre Madical	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	or 5+)	(Give	ive kind of work done during most of working b. DO NOT use retired) Homemaker 16b. Kind of Business/Industry 16b. Kind of Business/Industry 0wn Home									
ked othe Ic event,	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adolph Krall Ilka "unknows								n"				
27 is mar traumat	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
ant: If item ? ury or other		Susan S. Chidakel - daughter 11920 Bayswater Road, Gaithersburg, Maryland 20878 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetry, crematory or other place) Mount Lebanon Cemet. 07/18/2008 Adelphi, Maryland												
Import any inj once.		21. Signature of Funeral Service	7 / 4 ,	tem	ur I	Name a Danza 170	ind Addres insky- Rocky	s of Faci -Golo /ille	ity iberg e Pike	Memori , Rock	al C vill	hapel e, Ma	s, ry1	Inc. Land 20852
sician edical miner		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a Cardia	T III O	st	er the mo	de of dyin	g, such a	s cardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death
physician and the burial-transit	edical Examiner	Sequentially list conditions, if any Lading Limited Cause (Disease or injury that initiated events resulting in death) Last Congestive Heart Failure Due to for as a consequence of: C. Due to (or as a consequence of):								1	0 Years			
s been signed by the attending phy should be detached for use as the	Physician/Medio	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of In the past 12 months? 1 ☐ Yes 2 ☒No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐									ery Day Year			
en signed b uld be deta	δ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
certificate has ber rector, page 2 sho	Completed	24a. Was an autopsy prior to cordeath? 1 \(\text{Yes} \) 2\(\text{X} \) No \(\text{No} \) 1 \(\text{Yes} \)									opsy findings available impletion of cause of			
After this certificate has funeral director, page 2	To Be	25. Was case referred to medica examiner? 1 Yes 2 No	Hospital: 1 ☐ Inp	atient 2 🔼	`			er: 4 🗆 1	Nursing Hom	(Check only only only only only only only only	dence		(Speci	fy)
tor: After	Certification:										or Rue	al Route Number		
erai Direc		4 Homicide determined determined building, etc. (Specify)												
To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical one)	Examiner: On the bas and manner	is of examina	tion and/or ir	vestigatio	on, in my o	pinion, d	eath occurre	d at the time,	date and	d place, and	due t	o the cause(s)
₽ ऌ)		29b. Signature and title of certific	relly			ŧ	9c. Licens 330					te signed (/		
		30. Name and address of person Dr. Robert Gal	lino 18111	Princ	e Phil		rive	, 01ı	ney, M	arylan	.d 2	0832		
Sta Registi		31. Date filed (Month, Day, Year)	2. Reg	istrar's Signa		Es.								

ORIGINAL

DHMH 17 Rev 1/2001 OCMF 2006 OCME

		For State of Maryland / De	epartment of I C <i>ertificate of</i>			2001	0 21.700
		Registrar 1. Decedent's Name (First, Middle, Last)		Deain	2. Date of Dea	Reg. No. Z U U	3. Time of Death
Physicia		Charles R. Langley			Month July	Day Year 2008	
. /Medic Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of Death	oury	4c. County of Dea	
	•	Solomons Nursing Center	Solomon	ıs		Calvert	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days		8. Date of Birtl (Month, Day	9. Bi	rthplace (State or Foreign country)
Director		218-24-3307 ¹ ⊠м 2□ F 77 Y	s. Monato Bayo	110010	Aug. 1,		hington, DC
and	ł	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
Maryl	ţ	MD St. Mary's Leonard	torm				1 □Yes 2 🙀 No
r 28a	Director	100. Street and Number	10f. Zip Code			10g. Citizen of What C	country?
h witi	<u>a</u>	21689 Rosebank Road	20650			United Sta	ates
71213-UU36 within 72 hours after death with the Maryland fiene. than "natural", or items 23a or 28a-f show he Medical Evariner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of lif Yes, specify Cub	oan, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
IND 72 hours affine To hours affine "natural", or Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occu Give kind of work done life. DO NOT use retire	pation during most of worked)	ing	16b. Kind of Business	
d 21 filed wi Hygier other th	ပ္ပ		mmander		April 1 A B A C A A C A	Governme	nt
Maryland d 2 should be file th and Mental H ?? Is marked oth traumatic even	å	17. Father's Name (First, Middle, Last) Charles Ralph Langley		l	e (First, Middle, Ann Bos	Maiden Surname)	
hould and Me mark	은		Mailing Address (Stree				Zin Coda)
Ma Id 2 s Ilth an 27 is r trau		Manager Tanadan (TIES)	689 Rosebar				•
Baltimore, Maryland 2 Permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If Item 27 is marked other tany injury or other traumatic event, the any injury or other traumatic event, the		20a. Method of Disposition 20b. Place of I cemetery.	Disposition (Name of crematory or other pla	ace)	Date	20c. Location - City o	r Town, State
Baltir permit. F Departm. Importar any injur		21. Signature of Funeral Service Licensee Shawn Aylesworth M01521	22. Name and Addr	ess of Facility Br	insfield	Funeral H	· ·
		23a. Part 1. Enter the disease, or complications that caused the death. Do no		<u>-</u>			Approximate
Physician /Medical Examiner	er	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of any leading to immediate) Due to (or as a consequence of any leading to immediate)		nkalsuu	irl hu	restlage)	Interval Between Onset and Death
8/6/ ate be hysicia the bur	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d.	E	·-			
death e atter	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnan 5 ☐ Other (specify)			23d. Date of d Month	elivery Day Year
	ρ	Part II. Other significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting in the significant conditions contributing to death but not resulting the significant conditions contributing the significant conditions contributing the significant conditions condition	he underlying cause gi	ven in Part I.			to the cause of death? Probably 4 Unknown
0 a a 0	Completed	Demential Augusta			24a. Was a autop perfor	rtopsy prior to completion of cause of death?	
Of VITA Physician: r this certific ral director, I	Be	25. Was case referred to medical examiner?		26. Place of Deat			
Physical direction	2	1	Datient 3 1 DUA			lence 6 ☐ Other (Sp	necify)
on of ding Phys After this funeral di	ion	1 Natural 5 Pending (Month, Day, Year) Inj	ury Wo	uryat wrk? ⊒Yes 2 ⊒No	28d. Describe h	low injury occurred	
LIVISION OF VITAL HY To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Certification: T	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)			28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,
Hospital 24 hours Funeral etely fillec	Medical C	29a. Certifier (Check only one) 1	death occurred at the for investigation, in my	time, date and place opinion, death occur	, and due to the rred at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	29c. Licen	se number		29d. Date signed (Mor	nth, Day, Year)
		Pria and m mon	D00	47153		July 21, 2	2008
		30. Name and address of person who completed cause of death (Item 23a) (T Eric Berg, MD. 110 Hospital Road,		ederick h			
Star	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	TITHCE FI	CUCLICK, I	Tar y Lario		
Registra	-	JUL 2 3 2008					

			1 - State Amend #12 Registrar	State of the control	of Marylan 882 8/18	d / Depa 3 /08	artment of F <i>tificate o</i>	Health a f Death	and Mer		ene g. No. 200	8 24710	
	Physicia /Medic		Jules R Lodish July 14 20									3. Time of Death 6:20 am	
	Examin		4a. Facility Name (If not institut	ion, give street and no	ımber)		4b. City, Town	, or Location o			4c. County of Dea	th comery	
	Funeral Director		5. Social Security Number 293-40-3791	6. Sex 1 M 2 F	7. Age (In yrs.	Mari	If Under 1 Yea Months Day	r If Under	24 Hrs. 8. Min.	Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry) Ohio	
	aryland show	_	Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. Cit	y, Town or Lo	ocation			•		10d. Inside City Limits	
	ith the Ma or 28a-f	Director	Maryland 1 10e. Street and Number	Montgomery			10f. Zip Code	Bethes	da	10	1 X Yes 2 □ No		
	er death w	Funeral	11. Marital Status	Armed F		S. 13.	Was Decedent of	2081 f Hispanic Ori uban, Mexicar	igin? (Specify	Yes or No-	14. Race - Ame Black, Whit		
-0036	72 hours after death with the Maryland hatural", or Items 23a or 28a-f show digal Examinar must be redified at	þ	1 ☐ Never Married 2 🗷 M: 3 ☐ Widowed 4 ☐ Divorce		2 2 № ive Dates: 1973-	-1977	1 ☐ Yes 2 🖪 N			10	Specify: 6b. Kind of Business.	Caucasian	
21215-0036	vithin nne. han	Completed	(Specify only high	hest grade completed,	(1-4or 5+)	(Give	kind of work dor DO NOT use ret	ne during mos	t of working			ıl Science	
Maryland	2 should be filed w n and Mental Hygie is marked other t raumatic event, in	To Be C	17. Father's Name (First, Middle Harr	e, Last) y Leo Lodish				18. Mothe		rst, Middle, Ma na Lipkov	aiden Surname) witz		
	1 and 2 should Health and Mer tem 27 is marke other traumatic	13	19a. Informant's Name/Relatio								City or Town, State, . land 20817	Zip Code)	
altimore,		1 13	20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other		State	emetery, crei	osition (Name of matory or other p Memorial (· · · · · · · · · · · · · · · · · · ·	Date 07/17/2		Oc. Location - City or Falls Church	,	
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service	ce Licensee		H	2. Name and Add ines-Rina 1800 New	ldi Fune	ral Home		r Spring, Ma	ryland 20904	
Jacob Comment	Physician /Medical Examiner		23a. Part 1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	ist only one cause on		120 11				spiratory arres	st,	Approximate Interval Between Onset and Death	
8760,	ficate be executed physician and s the burlal-transit		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last	5 c	(or as a conseq					_		
O. Box 6	Physician: The law requires that the death certific this certificate has been signed by the attending p ral director, page 2 should be detached for use as:	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown			23d. Date of de Month	livery Day Year						
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									o the cause of death? robably 4 ☐ Unknown	
Vital Records,	iclan; The law re certificate has be ector, page 2 sho	Completed								24a. Was an autopsy perform 1 □ Yes 2	ed? prior to death?	utopsy findings available completion of cause of	
of Vit	Physiclan; this certifical director,	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 🗷 No	Hospital: 1 □	Inpatient 2		III JUDON	Other: 4 🗆 Nu	ursing Home		nce 6 Other (Spe	ecify)	
Division (Attending r death. sctor: After by the funer	Certification:	3 Suicide 6 □Coul	ding (Modestigation d not be remined 28e. Place	e of Injury nth, Day, Year) e of Injury - At h ling, etc. (Specia	28b. Time o Injury ome, farm, str y)	M 1	njury at /ork? □Yes 2□ e	No 28f.		v injury occurred eet and Number or R State)	ural Route Number,	
	Hospit 4 hour Funera tely fills	Medical C		ying Physiclan: To the all Examiner: On the and ma									
	To the comple	Ž	29b. Signature and title of certification	myr.	MO			ense number 2363	0	1	d. Date signed (Moni		
_	141		30. Name and address of person FRANK J. MAYO,	Mr 16220	FREDER	CK-RO	Print) # 213 , 6	NETHER.	18-26.	- 11 R'12 11	ND 2187	,	
	Sta Registr	_	31. Date filed (Month, Day, Yea JUL 17	2008	Registrar's Signa	ature	uli)						

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1 6 2008

32. Registrar's Signature

			For State Registrar	State of Marylan			of Health and of Death		iene2 0 0 8	24712	
	Physicia /Medic	al	George Lawrence Murphy, Sr. July 17, 2008 3:30								
	Examin Funeral Director	er	Sunbridge Care 5. Social Security Number 6. Sex 219-05-8023 1		last birthday) Yrs.	E1]	Year If Under 24 Hrs	S. 8. Date of Birth	Cecil	thplace (State or Foreign	
	Maryland -t show	tor	Usual Residence of Decedent 10a. State 10b. County Md. Cecil	10c. Cit	y, Town or Loc		lkton		10d. Inside City Limits Y☐ Yes 2 ☐ No		
	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-t show ha Madical Ezartinar must te molified a	erai Director	10e. Street and Number 76 Hollingswor	th Manor 12. Was Decedent Ever in U	C 12 W	10f. Zip C	21921		0g. Citizen of What Co		
9800	nours after de ural', or Item	d by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 StyYes 2 □ No If Yes, Give Year or Dates: WW 2	2 1	☐ Yes 2	<u>^</u>	rto Rican, etc.)	Black, Whit	e, etc. nite	
Maryland 21215-0036	d within 72 h giene. ir than "natu ir a Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance						16b. Kind of Business/Industry Civil Service		
yland	should be filed ind Mental Hygid marked other umatic event, to	To Be C	William A. Murphy Note: Name (First, Middle, Last) William A. Murphy Anna M. Moore							7. 0.41	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: It item 27 is marked other than "natural; or thems 23a or 28a-1 show any injury or other traumatic event, the Medical Examinating many bury or other traumatic event, the Medical Examinating the collision at once.		19a. Informant's Name/Relationship (Type Raymond L. Murp)	hy, Son	231 W	. Mai	in St., E	1kton,	Md 21921		
Baltimore,			20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ R ↑ 4 □ Donation 5 □ Other (Specify)		Place of Disposementery, cremetery, cremetery	atory or oth	er place)	150	20c. Location - City or 8 Elkton,		
Balti	permit. Departm Importa any inju		21. Signature Fund Service License	Э		_	Address of Facility G. Gee F		E. Main S		
760,	Physician and physician and physician site physician and physician site physician	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a consequence of the deather of the consequence of the c	uence of):	a n		ac or respiratory arr	est,	Approximate Interval Between Cnset and Death	
.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	il death 3 🗌	Ectopic pred Other (spec			livery Day Year		
<u>a</u>	w requires that I been signed by should be deta	ted by Ph	Part II. Dther significant conditions con	ntributing to death but not res	ulting in the ur	derlying cau	use given in Part I.		bacco use contribute t es 2 □ No 3 □ P	o the cause of death?	
Vital Records,	ilcian: The law r certificate has be rector, page 2 sh	Completed							med? prior to death?	utopsy findings available completion of cause of	
	Physician: r this certificated director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3□ DOA	Othos	eath <i>(Check only or</i> Home 5 ☐ Resid	ence 6 □Othe <i>r (Spe</i>	ecity)	
o uo	Attending PI or death. ctor: After till by the funera		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 280	c. Injury at * Work? 1 □ Yes 2 □ No	28d. Describe h	ow injury occurred		
Division of	o afte o	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre	treet and Number or R n, State)	ural Route Number,				
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sician: To the best of my knoner: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at restigation, in	t the time, date and place n my opinion, death occ	ce, and due to the courred at the time, o	ause(s) and manner a date and place, and du	s stated. e to the cause(s)	
)	To th withir To th comp	Me	29b. Signature and title of certifier		IN	29c.	License number	449	29d. Date signed (Mon	th, Day, Year)	
			ato, Name and addresse of person who co		п 23а) (Туре.	Print	SI	200 1	1101	UN 21921	
2	Sta Registi		31. Date filed (Month, Day, Year) JUL 2 1 2008	2. Registrar's Signa	ature	B)	Jui Je	wa c	Into	-WX (X)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JuÏÿ 2008 15 Betty Jean Miller 8:30 a.M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Dorchester Dorchester General Hospital Cambridge | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. | March 27,1937 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 □ M 2 🔽 F Maryland 220-32-5176 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√2 No MD Dorchester Madison 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1243 Old Madison Road 21648 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑No Specify. Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herbert F. Thompson Sr. Ellen May Reeley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dennis B. Miller 2413 Pinecrest Lane, Fredericksburg, VA son 22408 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ∑Burial 2 □ Cremation 3 □ Removal from State Old Trinity Churchyard 7/18/08 Church Creek, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licenses 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part IL-Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Winknown 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2/3 No 1 npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No € ☐ Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Physician /Medical Examiner Physician/Medical Examiner P.O. Box 68760.

Physician

/Medical

Examiner

Directo

Funeral

Completed by

Be

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

be filed within 7 al Hygiene.

nd Mental marked o should be

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of Health item 27 i

Pages 1 tment of F

other

ō parmit. Page Department of Important: If any Injury or once.

72 hours after death with

Baltimore, Maryland 21215-0036

attanding physician and for use as the burial-tran signed by the page ;

Completed by

Be

Certification: To

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

the death certificate ba executad After this funeral of To the Hospital or Attending death. within 24 hours after deaft To the Funeral Director completely filled in by the

or Vital Records,

Division

State Registrar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29c. License number

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2000

Physicia /Medic Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any hjury or other traumatic event, Its Medical Evantive must be notified at once.

NAME KNOWN TO PHYSIEIAN: MEDONALD, ANON DOYLE

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - State Registrar	Certificate of L	Death	Reg. No	.2000	24/14				
	1. Decedent's Name (First, Middle, Last)			2. Date of Death	av laYear	3. Time of Death				
ıl	Anon Doyle McDonald			10/1 11	4 4001	5:45 A.M				
r	4a. Facility Name (If not institution, give street and number) VA MARYLAND HEALTHEARE SYSTE	em pei	Location of Death	+	c. County of Death	16				
	5. Social Security Number 260-32-1894 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. las	Yrs. If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Year April 2 1	927 F101	nplace (State or Foreign Intry) rida				
		Town or Location				10d. Inside City Limits				
į	Maryland Caroline Gre	eensboro				1 □Yes 2 X No				
Completed by Funeral Directo	10e. Street and Number	10f. Zip Code		10g. C	Citizen of What Country?					
ra L	25570 Linhard Lane	21639		U	USA					
nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Spec n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White					
y F	1 ☐ Never Married 2 █ Married 1 █ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Q / 5 — /	1 □Yes 2 🛣 No	Specify:		Specify: Wh	ite				
ed	1743	16a. Decedent's Usual Occup	ation	16b.	Kind of Business/li	ndustry				
ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired	luring most of workin)	g						
Co	07	welder			1 tanks					
Be	17. Father's Name (First, Middle, Last)			(First, Middle, Maide	,					
٩	William Lee McDonald	10) 14 77 11 11 10		ae Wood Me						
	19a. Informant's Name/Relationship (Type. Print) Frances E. McDonald/ wife	,		el Route Number, City or Town, State, Zip Code) eensboro, Maryland 21639						
	20a Method of Disposition 20b, Place	ce of Disposition (Name of	Da		Location - City or T					
	1 LABurial 2 LI Cremation 3 LI Removal from State	netery, crematory or other place sterfield Ceme	1	9/08 Cen	treville.	, Maryland				
	21. Signature of Funeral Service Licensee	22. Name and Addre	ss of Facility							
	Itush Chlunge	Fleegle at PO Box 160	Greensb	oro, MD 2	1639					
	23a. Part 1. Ent if the disease, or complications that caused the death. shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition	•								
	disease or condition resulting in death) a. N U V N N	,		Olabliohala						
	Sequentially list conditions, b.									
iner	ritariy, leading to immediate cause. Enter Underlying	ince of): At 7 TA kt								
хаш	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence)	IND INN								
Medical Examiner	4									
edic	- U			- 1						
_	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnanc		v		23d. Date of deli					
Completed by Physician	in the past 12 months? 1		,	Month	h Day Year					
Ph)		ing in the underlying cause giv	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?				
ğ Q	Part II Other significant conditions contributing to death but pot resulting to the significant CARD ALL AND UFFICIAL	ENCY		1 □ Yes	Yes 2 No 3 Probably 4 Unknown					
olete	ĺ			24a. Was an	24b. Were au	topsy findings available				
E O	autopsy performed? 1 Yes 2 1 Yes 2 25. Was case referred to medical examiner?									
Be										
၉		R/Outpatient 3 ☐ DOA Oth 28b. Time of 28c. Injur	4 LI Nursing Hor	ne 5 Residence		cify)				
tion	1 IX Natural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation	Injury Wor	yat ⟨? Yes 2 □No	28d. Describe how inj	jury occurred					
ifica	3 Suicide 6 Could not be 28e. Place of Injury - At hom	ne, farm, street, factory, office		28f. Location (Street:	and Number or Ru	ral Route Number,				
building, etc. (Specify) City or Town, State)										
Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowl 2 Medical Examiner: On the basis of examination and manner stated.	ledge, death occurred at the ti on and/or investigation, in my o	me, date and place, a pinion, death occurre	and due to the cause ed at the time, date a	e(s) and manner as and place, and due	s stated. to the cause(s)				
Me	29b. Signature and title of certifier	Mil) 29c. Licens	e number		Date signed (Month					
	The A pastime	1	14041	07-	-14-2	008				
	30. Name and address of person who completed cause of death (Item 2	23a) (Type, Print) ARYLAND HEA	LTH CARE	SYSTEM.	PERRY	LOPIL MA LIGOL				

State Registrar 5 HER A. NA.
31. Date filed (Month, Day, Year) JUL 1 5 2008



DHMH 17 Rev 1/2001

as G+

			1 - For State Registrar	Otato of N	rai y lai la	Cer	tificate of	Death	vicinaiii	Reg. No.	2008	24/13
	Dhysisi		1. Decedent's Name (First, Middle,	Last)		_			2. Date of D	Death Day	Year	3. Time of Death
	Physici /Medic		Catherine An	n Maule					07	20	2008	3:20 A M
	Examin	er	4a. Facility Name (If not institution,					r Location of Death	1	4c. (County of Death	
1			Oakland Nursing			-46:41-4-3	Oakla If Under 1 Year		T 0 D-1 / E		arrett	
Ŀ	Funeral Director		5. Social Security Number 233-52-8618 Usual Residence of Decedent	5. Sex 7. A 1 □ M 2 X F	Age (In yrs. la:	Yrs.	Months Days	Hours Min.	8. Date of E (Month, L	Day, Year)	9. Birthp Coun Mary	lace (State or Foreign itry) land
	/land ow at		10a. State 10b. County		10c. City,	Town or Loc	cation				1	0d. Inside City Limits
	a-f sh iffed	ctor	MD Garr	ett	Mo	untair	n Lake Pa	ark				1 X Yes 2 ☐ No
	th the or 28	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Coun	itry?
	23a ust b	<u>6</u>	607 N Street #	19			2155	0			USA	
	r dea	Inel	11. Marital Status	12. Was Deceder Armed Forces	3?	. 13. V	Vas Decedent of H f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No Rican, etc.)	No- 1	4. Race - Americ Black, White,	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Marrie 3 🖾 Widowed 4 ☐ Divorced	if Yes, Give	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No Specify:				Specify:	ite
5-0	"natu	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	lent's Usual Occup kind of work done	pation during most of wor	king	16b. Kin	nd of Business/Inc	dustry
121	within ene. than the Me	d m	Elementary/Secondary (0-12)	College (1-4o	College (1-4or 5+)		(Give kind of work done during most of working life. DO NOT use retired) aundry Worker			N		
d 2	filed Hygid ther		5th 17. Father's Name (First, Middle, L	ast)		Laun	dry work	18. Mother's Nan	ne (First, Midd		sing Hom	ıe
Maryland	d 2 should be fi th and Mental H 7 is marked otl traumatic ever	To Be	James Franklin	Somerville				Minnie	Ime		,	
ary	shou ind M inar	-	19a. Informant's Name/Relationshi			19b. Mailin	g Address (Street	and Number or Ru			Town, State, Zip	Code)
	t and 2 Health a em 27 is		Betty M. Murphy	/ Daughte:	r			inderwood				
J'e	of He of He fitem		20a. Method of Disposition		20b. Pla	ce of Dispos	sition (Name of natory or other pla	i	Date		cation - City or To	
Ē	Pages nent of I ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp.		e			Cem. 7/22	/2008	Oak	land, MI)
Baltimore,	permit. Pag Department In portant: I any Injury o		21. Signature of Funeral Service L	censite		22	. Name and Addre	ess of Facility St	ewart I	unera	1 Home	land 21550
			23a. Part1. Enter the disease, shock, or heart failure. List o	omplications that caus	ed the death.						id, Hary.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	P 4	who a	200	CAUR	00 -	meta	44		Onset and Death
	/Medical		resulting in death)	a. Due to (or	a cons	nce of):	canc	ue	"Tura	7 101	0	Lucers
	Examiner		Sequentially list conditions	b	U							
	₽ # <u></u>	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a conseque	ence oi).						
	ecute and trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	c								
60,	be ex cian a	E	Tooling in Journ J Last	Due to (or a	as a conseque	ence ot):						
68760,	rtificate be executed ng physician and as the burial-transit	dici	`	d								
			IF FEMALE:	23c. If yes, outcom	ne pf pregnan	cy				2	2d Date of delive	
Box	law requires that the death cel as been signed by the attendir 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No	1 ☐ Live birth	2 Fetal of at time of dea	death 3□	Ectopic pregnanc Other <i>(specify)</i>	у			3d. Date of delive Month	Day Year
0	t the c by the achec	hysi	9 ☐ Unknown	9□Unknown			,,,,,,					
Э,	ires that the de signed by the a be detached f	by P	Part II. Other significant condition	s contributing to death	but not result	ting in the ur	nderlying cause giv	ven in Part i.	23e. Did	d tobacco us	se contribute to th	ne cause of death?
ğ	w require been sig should b	ed k	avenua, a	cull per	nalp	aule	ine		1	Yes 2	(No 3 □ Prob	pably 4 □Unknown
Records,	ne law requ has been ge 2 should	Completed		_	U				24a. Wa		24b. Were auto	psy findings available
æ	The ate h	É							pe	topsy rformed? 2 No	death?	mpletion of cause of 2□ No
Vital	iclan: Th certificate ector, pag	Be (25. Was case referred to medical examiner?	II.				26. Place of Dea				
or \	physic this co	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa		R/Outpatien		4 Nursing F	lome 5 ☐ Re	sidence 6	Other (Specif	y)
n	ing F After uner	ü	27. Manner of Death 1 Natural 5 ☐ Pending		njury 2 Day Year) 2	28b. Time of Injury	Woi		28d. Describ	e how injury	occurred	
Sic	ttend death stor: the	cat	Accident investigation 3 Suicide 6 Could no	ot be	niun. At hom	an form str	M 1 □ eet, factory, office	Yes 2 No	00((i	(04		
Division	i or A after d Direc	Certification:	4 ☐ Homicide determin	building,	etc. (Specify)	ne, iaim, siie	eet, factory, office			own, State)	d Number or Rura	il Houte Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: , completely filled in by the f	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis	of examination	rledge, death on and/or inv	n occurred at the ti	ime, date and place opinion, death occ	and due to the urred at the time	ne cause(s) ne, date and	and manner as s	tated.
	o the ithin (o the omple	Med	29b. Signature and title of certifier	and manner	sialed.		29c. Licens	se number		29d. Date	e signed (Month,	Dav. Year)
b	⊬s⊢ŏ		Masser	+ a.K.		11	4	7/1/2				
			30. Name and address of person w	tho completed cause of	f death (Item 3	23a) (Type	Print)	4650			06-4	00
		3	maranost a L	assor 1	ad	1307	9 Runs	H hirsh.	1.84 1.1	Du	6 Ours	000 Md 21550
	Sta		31. Date files (Month, Day, Year)	9 2009 32. Regis	trar's Signatu	ire N	All Ro	July	1	will	in deliberation,	
	Registi	rar	U JUL 2	\$ 2008	The state of	The state of	5					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22^{Day} 2008 July **Physician** 11:30 A_M Watson Mowbray /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Talbot. 28197 Easton Glebe Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) June 30 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 215-12-2475 1 XM 2 □ F 88 Maryland 1920 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County MD. Talbot Easton 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 28197 Glebe Road 21601 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married white 1 □ Yes 2 🖾 🗓 o Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Appliance Manufacturer Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Matthew Mowbray Tennant Mary ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Mowbray/ wife 28197 Glebe Road, Easton, Maryland 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. View Cemetery Barton, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Boal Funeral Home 02 111 Church St, Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final reunes disease or condition resulting in death) Due to (or as a consequa ce of): Sequentially list conditions, frank, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No 1 ☐ Innatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) P 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural

/Medical **Examiner** The law requires that the death certificate be executed burial-trar Box 68760, physician the buria 38 attending for P.O. been signed by the should be detached Division or Vital Records,

cate has page 2 s

director,

funeral

certificate

After

within 24 hours after death

To the Funeral Director:
completely filled in by the

Medical

12

State

Registrar

To the Hospital or Attending Physiclan:

death.

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is rr any injury or other traum once.

Physician

Certification:

Injury

21601

(Month, Day Year) 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier (Check only one)

2 ☐ Accident

3 ☐ Suicide

4 Homicide

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature a title of certifie

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

o. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. David Smith 8221 Teal Drive, Suite 302, Easton, MD. 30. Name and add

31. Date filed (Month, Day, Year) JUL 4 2008 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2008 Edna M. McConnell 20 Ju₁y /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bayside Care Center Lexington Park St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F 86 Director 218-80-3803 1921 Pennsylvania 4, Usual Residence of Decedent 10b. County 10c. City, Town or Location Directo Lexington Park St. Mary's Maryland 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 48218 Far Cry Road 20653 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 □Yes 2**X** No Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other the any injury or other traumatic event, Ite. ORG. Homemaker House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Alice McDowell ည Henry Ray Corbin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Arthur McConnell 48218 Far Cry Road, Lexington Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols 107/23/2008 Charlotte Hall, MD 21. Signature of uneral Service Leavard N. Brinsfield, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Hom Leonardtown, MD 20650 Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician ar P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown 23d. Date of delivery 1 Live birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 - Ectopic pregnancy Month 5 ☐ Other (specify) signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 1 □Yes

Division of Vital Records, Hospital or Attending Physician: 24 hours after death. this certific al director,

Certification: Director:

25. Was case referred to medical examiner? Be 1 Yes 2 No ပ 27. Manner of Death

Medical

1 Natural 2 Accident 3 Suicide

4 Homicide

(Check only one)

JUL 2 3 2008

29a, Certifier

6 Could not be determined

5 Pending investigation

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

Hospital:

1 Inpatient

28a. Date of Injury (Month, Day, Year)

29c. License number 46046 MU

1 ☐Yes 2 ☐No

28c. Injury at Work?

26. Place of Death (Check only one)

Other: 4XXIursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) -21-2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3. Time of Death

10d. Inside City Limits 1 ☐ Yes 21 No

20653

Day

2 No

Year

Approximate Interval Betweer Onset and Deat

9:00

P M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amir Mirza Alikhan, M.D. 101 Centennial Avenue, LaPlata, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ROLAND REESE McKAY Ju 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner rince Prince وأبد Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 🖾 M 2 🗆 F Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min Months Hours 220-26-6611 Yrs. **Director** 82 04/24/1926 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show Pages 1 and 2 should be filed within 72 hours after death with the Marylai ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show usy or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | St. Mary's Valley Lee 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20692 United States 18867 Windy Piont Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XiYes 2 ∐ No If Yes, Give 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Transportation Bus Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice Goldsbourgh Joseph Roland McKay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18867 Windy Point Lane Valley Lee, Maryland 20692 Mollie Rea McKay / Wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Cre 07/21/2008 | Charlotte Hall, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01206 Kyle S. Simons 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Blaten numbrary Contusion Physician 40055 gre 27 resulting in death) /Medical Due to (or as a consequence of): Examiner vehicle accident motor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and I be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, pe Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 1 □Yes 2 □ No 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 cerebra anoxia 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown should Completed Cardlophimonary 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate Wethiallin weggtant 1 ☐Yes 2 ☐No Attending Physician: 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28d. Describe how injury occurred Front Sect PASS enger in MVA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: Division 1 □ Natural 5 ☐ Pending investigation July 15 2008 2 2215 M 1E 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office

28f. Location (Street and Number of Qural Boute, Number,
City of Town, State)

28f. Location (Street and Number of Qural Boute, Number,
City of Town, State) 4 | Homicide ō Hospital 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July mo 6 12008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G Horp 3001 Hospital Drive, Cheverly, Maryland WilliAm BOYCE Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 1 2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month **Physician** 7:38 p M 13 Martin Meyerson 2008 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months 1**K** M 2□ F 80 Yrs. Director October 22, 1927 New Jersey 143-20-3261 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner to ust be notified at Director 1 □Yes 2 KNo Rethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20814-2027 5225 Pooks Hill Road, #1801 South U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene.
net if Item 27 is marked other than "natural", or ite marked other than "natural", or ite in yor other traumatic event, Item Moderal Exercisis 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No <u>ک</u> Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Electrical Engineer Aeronautical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Max Meyerson Annie Slobodin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5225 Pooks Hill Road, #1801 South, Bethesda, Maryland 20814-2027 Ann Meyerson - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of I
Important: If It
any injury or o
once. 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) Judean Memorial Gardens 07/17/2008 Olney, Maryland 4 □ Donation 21. Signature of Fyneral, ervice Liq 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the dise a shock, or heart failu +. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death list only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ned by the a detached f ☐Yes 2☐No 9 Unknown 9 ☐ Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 17 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica (completely filled in by the funeral director, p. ers after death.

eral Director: After this certifica filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo 1 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 7118108 S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive, Suite #201, Rockville, Maryland 20850 Truong Bao, M.D., 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 17 2008 JUL Registrar

REVERSON, MARTIN

attending physician and for use as the burial-trar P.O. Box 68760, Records, Division of Vital

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Magth 07th 0^{Year} 11:17 AM Morris Sandra Jean 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ALLEGANY WHMS-BRADDOCK CAMPUS CUMBERLAND 8. Date of Birth (Month, Day, Nov 26, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Days Hours 1 □ M 2 🙀 F 1944 215-42-4601 ЙD 63 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Allegany Cumberland 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11215 Brown Hill Road 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □Xo Specify: Specify: 3 Widowed 4 Divorced white 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Claude Hardinger Lillian Hardinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11215 Brown Hill Road Richard Morris Cumberland MD 21502 son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Restlawn Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/30/2008 LaVale MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death DAY 23a, Par 1. Enter the disersity or complicity insituation caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Examiner CELLULITIS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OBSTRUCTEVE DISTACE 1 Pres 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 54004 Name and address of person who completed cause of death (Item, 23a) (Type, Print) Hwy, La Vale, Maryland National 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Physician 07 1200 25 2008 Harold Meyers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALLEGANY MEMORIAL HOSPITAL CHMBERLAND If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 F MD Apr 14, 1929 Director 723-14-7027 79 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County a or 28a-f show be notified at 10d. Inside City Limits MD Allegany Cumberland 1. Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r Items 23a (Iner must b 139 Humbird Street 21502 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23s 12. Was Decedent Ever in U.S. Armed Forces? 1★1 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) or than " Elementary/Secondary (0-12) College (1-4or 5+) Machinist B & O Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James C. Mevers Cora V. Johnston Meyers ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 139 Humbird Street MD 21502 Helen Meyers wife Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Park 7/28/2008 MD Cumberland 4 Donation 5 Other (Specify) 21. Signatur f Fun rail Service 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. art / Enter the disease or conscilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I me diate ause (Final disease o condition resulting in death) ACUTE RESPIRATORY FAILURE **Physician** /Medical Due to (or as a consequence of): Examiner SDIRATION PHEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans CARDIOVASCULAR Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy page 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Anatural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 ☐ Pending after death.

I Director; Af in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 3☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0066101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 SETON DR., CUMBERLAND MD 21502 ABOU L Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Joseph Elder Meckley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Carroll Westminster If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months **★**□ M 2□ F Director 212-12-5478 88 May 26 1920 MD 10c. City, Town or Location 10a. State 10b. County 10d. Inside Cify Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at MD Carroll Finksburg 1 ☐ Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2315 Sandy Mount Road 21048 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1XXYes 2 No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. ģ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Carpenter/Construction Cumins & Hart 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Franklin Meckley Ora Barnhart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 590 Rich Mar Westminster, MD Doris Jean Powell/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State Sandy Mount UMC Cem 07/21/2008 Finksburg, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Printes Aftererally Home and Chapel, P.A. M 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in list age of the cause). Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at the detached for 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division or Vital Records, To the Hospital or Attending Ph within 24 hours after death.

> To the Funeral Director: After th completely filled in by the funeral WIL IOTIVA

Baltimore, Maryland 21215-0036

P.O. Box 68760,

FRANCIS KHOU, MD

29c. License number 30263 29d. Date signed (Month, Day, Year) 7-15-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 MEMORIAL AVE, WESTMINSTER, MD

31. Date filed (Month, Day, Year) JUL 18 2008

29b. Signature and title of certifier

32. Registrar's Signature Coarte

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended #28b perMD FCHD DC Certificate of Death 7/16/08 008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ANITA MARIE MENARD 11 2008 A^{M} JULY 7:21 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) APR 30 Birthplace (State or Foreign Country)
 NY 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** Months Hours Days Year) 577-40-9970 1 □ M 94 1914 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No MD MONTGOMERY CLARKSBURG Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 20871 12703 YORK MILL LANE USA death v Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: Specify: ģ WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) HOSPITAL AND Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE CARE REGISTERED NURSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12703 YORK MILL LA., CLARKSBURG, MD 20871 of Health a JEFF MENARD / SON Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If iter any Injury or oth 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) STAUFFER CREMATORY 7/15/08 FREDERICK, MD 22. Name and Address of Facility
HILTON FUNERAL HOME 21. Signature of F 20838 P.O. BOX 86, BARNESVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician **ASCVD** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of burial-transi Exami Due to (or as a consequence of) the attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregna Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 I Inknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 HIP FRACTURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time oUNK 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation TRIPPED OVER FRACTURE 1 ☐ Yes 2 No 130/06 spital or Attendi nours after death. neral Director; A y filled in by the fu 2 Accident 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide HOME 14639 BAVERDR. ROKKVILLEND within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D50276 JULY 15, 2008 30. Name and addre soft person who completed cause of death (Item 23a) (Type, Print) U

State Registrar 31. Date filed (Month, Day, Year)

SANGEETA SIMLOTE,

MD 3411 OLANDWOOD CT., #105, OLNEY, MD 20832

32 pegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2008 **Physician** 15, Ju₁v Bettina Newman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours 1 □ M 2**XXX** Yrs. Director 94 1914 074-05-9537 June 4, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Wedical Examinar must be notified at 10c. City, Town or Location 10b. County Director Odenton Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2608 Hoods Mill Court # 404 21113 White Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status □Yes 2 XNo Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Completed by 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin Simon Rose Mier 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2608 Hoods Mill Court #404 Odenton, MD 21113 Howard Ginsburg/ Son 20b. Place of Disposition (Name of cemetery, crematory or other plac Star of David Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/18/2008 North Lauderdale, FL 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) otic **Physician** Athenosc /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dementio Due to (or as a consequence of): P.O. Box 68760,

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

Pregnant at time of death

Be

Medical Certification: To

Physician/Medical IF FEMALE: 23b. Was decedent pregnant Par þ Completed 25

in the past 12 months?

1 ☐Yes 2 ☐No

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Fuheral Director: After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 2 should be detached for use as the burial-transit

of Vital Records,

Division

3 - OTIKITOWIT					
Part II. Other significant conditions	contributing to death but not resulting			d tobacco use contribute to t Yes 2 No 3 Pro	
			pe	as an topsy prior to conformed? 1	opsy findings available ompletion of cause of 2 □ No
25. Was case referred to medical examiner?		21	6. Place of Death (Check only	(one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/0	Outpatient 3 DOA Other:	4 Wursing Home 5 ☐ Re	sidence 6 Other (Spec	ify)
27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	Time of Injury at Work?	28d. Describ	e how injury occurred	

3 🔲 Ectopic pregnancy

5 Other (specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

5:25

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 X Yes 2 □ No

West Germany

14. Race - American Indian.

White

Black, White, etc.

23d. Date of delivery

Month

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1/2 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29d. Date signed (Month, Day, Year) D20108 th anono MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14300 GALLANTFOXLN#222. BOWLE MD20715

1 ☐ Yes

2 🗌 No

Registrar

1 Natural 2 Accident

4 Homicide

3 Suicide

5 ☐ Pending investigation

6 ☐ Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Otate of Maryland		rtificate of			eg. No. 20	08 24725	
	Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of Death	Day 200	3. Time of Death 3: (0 P M	
	/Medic Examin		Leonor Or 4a. Facility Name (If not institution, give	maza e street and number)		4b. City. Town. or	r Location of Death	July	4c. County of I		
	Examini	CI	CIVISTA MEDI			LAPL	47A		Char		
	Funeral Director		5. Social Security Number 6. Si 101 64 1248 Usual Residence of Decedent	ex 7. Age (In yrs. I. XX 96	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, July 1,		Birthplace (State or Foreign Country) Cuador	
	yland yland		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits	
١,	e Mar	ctor	Maryland Charles		Wald	dorf				1 □ Yes 2√√No	
C.	ath with th 23a or 20 ust be no	Funeral Director	10e. Street and Number 4177 Old Wash			10f. Zip Code 20602			10g. Citizen of What Country? Ecuadorian		
LECNOK 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantment rust be notified at once.	Completed by Fune	11. Marital Status 1 □ Never Married 2 □ Married **MM* Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forees? 1]	Y¶Yes 2□No	dispanic Origin? (Spean, Mexican, Puerto Specify: Ecuador	ian	Black, \ Specify:	American Indian, White, etc. White	
7 5	in 72 in n "nat	plete	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	pation during most of worki d)	ng	16b. Kind of Busin	ess/industry	
212	d with giene, er than	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)		amstress			Texti	.le	
Hand	uld be file Menta! Hy arked othe	To Be (17. Father's Name (First, Middle, Last) Segunda				18. Mother's Name		Maiden Surname) a Santos		
Mar.	and 2 sho ealth and n 27 is ma		19a. Informant's Name/Relationship (Nestor Henrique	z- Nephew	417	77 Old Wa	and Number or Rura shington	Road, Wa	aldorf, M	ID 20602	
) R.M.	Pages 1 ment of H tant: If iter lury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Tr	inity	Memorial	1	l V		Maryland	
Baltim	permit. Depart Import any Inj	1 13	21. Signature of Puneral Service Licen	5 MO146			Ferry Ro			Inc 6633 01d 20735	
o	Physician /Medical Examiner	er	23a Part 1. Enter the disease, or comy shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence) Due to (or as a consequence)	uepce of):	HEROS C	CENOSI	5.		Approximate Interval Between Onset and Death	
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Brzy Hys Due to (or as a consequent		Vescul	se Di	s case		ageon	
	ertific ding p	/Med	IF FEMALE:	22a If you guitagma of progras							
.O. Box	the death cer by the attendin ached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of Month	•	
rds, P.	w requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	inderlying cause giv	ven in Part I.			ute to the cause of death?	
Division of Vital Records,	sician: The law re certificate has ber rector, page 2 sho	Completed						24a. Was a autops perform	sy prio med? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 □ No	
/ita	ystcian: iis certific director,	Be	25. Was case referred to medical examiner?			i i	26. Place of Deat	n (Check only or	ie)		
of	Physi this c		1 ☐ Yes 2 🛣 No 27, Manner of Death	Hospital: 1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatie	nt 3 DOA Oth	ner: 4 ☐ Nursing Ho		ence 6 Other	(Specify)	
on	Attending Phyrdeath. ector: After thiby the funeral of	tion	1 ► Natural 5 □ Pending 2 □ Accident investigation	(Month, Day, Year)	Injury	Wor	rk?]Yes 2 □No	200. Describe in	ow injury occurred		
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Injury - At ho building, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location (S City or Town	treet and Number n, State)	or Rural Route Number,	
	ne Hospit n 24 hours ne Funera pletely fille	Medical ((Check only 2 ☐ Medical Exar	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, dea ation and/or i	th occurred at the t nvestigation, in my	ime, date and place, opinion, death occur	and due to the or red at the time, o	cause(s) and mani date and place, an	ner as stated. d due to the cause(s)	
	To the Complexity	ž	29b. Signature and title of certifier	1 1		29c. Licens	se number	2	29d. Date signed (Month, Day, Year)	
	Q E I	<	3º. Name and addres of pason who	completed cause of death (Iten	n 23a) (Type	Print)	0627	2	1111	4100	
	00	ate	31. Date filed (Month, Day, Year)	completed cause of death (Iten THEN MD 1 32. Projectar's Signa	1345 iture	tembrook	ke 54.#10	3 Wa	ldorf	MD 70603	
	Regist			2008 Aleene.	H B	barle					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Robert Kenneth Ogden Ju 19th 14 2008 3:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 60 Main Street Calvert Prince Frederick If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day Sept 22 Social Security Number 9. Birthplace (State or Foreign **Funeral** 219–16–2199 1 ★M 2 F 82 Mary Tand Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at Maryland Calvert Prince Frederick Director 1 ☐ Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 60 Main Street 20678 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 XYes 2 No
If Yes, Give 44-46
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) service station manager Service Station/Auto 17. Father's Name (First, Middle, Last)
James Howard Ogden, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Hance 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zio Code)
P. O. BOX 96 Prince Frederick, MD 20678 Jennifer L. Milligan - granddaughter 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Wesley Cemetery July 18, 2008 1 Burial 2 □ Cremation 3 □ Removal from State Prince Frederick MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final R TENOSIS **Physician** year disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit death certificate be executed Due to (or as a consequence of) P.O. Box 68760, signed by the aftending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, NS10 1 □ Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has performed? res 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2019 Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner eath 1 Watural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After Certification: Injury 5 ☐ Pending investigation 1 Yes 2 No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day J Year) W D PHYSICIAN TICKDING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUNSHI M.D. 110 HOSFITTL RD PRINCE

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Registrar

31. Date filed (Month, Day, Year) JUL 17 2008

ANWIR

32. Registrar's Signature b.K

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Jin I 0910M 2008 15 Pollard Edward /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Talbot Memorial Hospital teston 1-astor at If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 9 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) 5. Social Security Number 6 Sex **Funeral** Days Hours Min. Maryland 1 XM 2 ☐ F 60 1948 March 219-46-3870 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 28a-f show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2X No Director Maryland Caroline Ridgely 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21660 U.S.A. 11155 Central Ave. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Examiner: 1 Never Married 2 X Married 1 ☐ Yes 2 【XNo Specify: White Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) industrial Millwright 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise Hickman Pollard Woodrow Wilson Pollard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11155Central Ave.; Ridgely, Maryland 21660 Marcella Pollard/ 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 07/20/08 Ridgely Cemetery Ridgely, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Fleegle and Helfenbein Funeral Home, PA PO Box 160; Greensboro, MD 21639 21. Signature of uneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HMonths Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): the attending physician and for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by t , page 2 should be detach 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hash performed After this certificate or Attending Physiclan: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 ☐ Yes 2 **□** № 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death. the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 08 Name and address of person State JUL 1 7 2008 Registrar DHMH 17 Rev 1/2001

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 07 **Physician** 5:50 P M 20 2008 William Pifer, Sr. Clarence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett Co. Memorial Hospital Garrett 0akland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1⊠M 2□F 02/27/1942 Director 66 Maryland 220-38-0425 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 □Yes 2KINo Director 0akland MD Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21550 1744 Hutton Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 HNo Baltimore, Maryland 21215-0036 þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Self Employed Elementary/Secondary (0-12) College (1-4or 5+) 10th Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Wade Pifer Bernice A. Moats ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence W. Pifer, Jr./ Son Rt. 1 Box 352A, Aurora, West Virginia 26705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 07/25/08 4 Donation 5 ☐ Other (Specify) Omega Crematory Morgantown, WV 21. Signature of Ineral Se Licensee 22. Name and Address of Facility Stewart Funeral Home 32 South Second Street, Oakland, Maryland 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** immediate Acute Myocardial Infarction /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Tilnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an lung infiltrate autopsy perform 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA မ within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 💆 Naturai (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/21/08 D15333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Fourth Street, Oakland, MD 21550 Thomas G. Johnson, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Examiner The law requires that the death certificate be executed physician and s the burial-trans Box 68760. o. the signed by the ۵. or Vital Records, peen this Division To the Hospital or Attending

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

death. after

Physician /Medical Certification: 5 ☐ Pending investigation 7:10 p M 1 ☐ Yes 2 ☑ No Choked on food July 11, 2008 2 Accident 3 ☐ Suicide Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, #7, City or Town, State) / Dalamar St., #7, determined 4 Homicide Restaurant within 24 hours aft To the Funeral Di completely filled in Gaithersburg, MD 20877 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier reen 29c. License number 0 30112 July 14, 2008

State Registrar Virendra K. Saxena, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850

VIOLENDAM K SAXEM

32. Registrar's Signature

3 Name and address of person why completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month) Pay, Year) 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 15, July 2008 2:36 P.M Pyatigorsky Ernestina 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Mar. 4, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Hours 1□M 2√F Months Days 137-70-7596 88 1920 Ukraine Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6121 Montrose Road 20852 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Years Librarian Public Library 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tsetsilia (Unknown) Ainsaft Samue1 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 14005 Saddle River Drive, N. Potomac, Maryland 708 78 Lily Lubin - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 7/17/2008 Judean Mem. Gdns Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 15 minutes rewell dicease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month 4□Pregnant at time of death 2 0 NO 9∏Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 No 2 7 No 1□ Yes 26. Place of Death (Check only one) Other: 4 varsing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No

certificate be executed Box 68760. signed by Division or Vital Records, YATIOG FOSKY ial or Attending Physician: The safter death.

I Director: After this certificate ed in by the funeral director, pag

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Be Completed

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an "natural", or items 23a or 28a-f show Medical Examiner must be notified at

filed within 72 hours after death

al Hygiene.

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien important: if Item 27 is marked other tt. any Injury or other traumatic event, the once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Be Completed 25. Was case referred to medical examiner?
1 ☐ es 2 □ No Certification: To 27. Manner of Death 1 Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 **certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated

D0036716

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

7

5008

29b. Signature and title of certifier



una

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



To the Hospital of within 24 hours af To the Funeral D completely filled in

Box 68760. P.0. Division or Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

29a. Certifier (Check only

29b. Signature and title of pertifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day,

and manner stated.

D0023322

7.16 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S Scolder MD (18 North

Suite 3B, Elkon MD21921

State Registrar

Medical

Year



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryl	land / Depa <i>Cel</i>	artment of Health rtificate of Death	and Mer	ntal Hygiei	ne 2008	3 24732
	Dhysisi	-	Decedent's Name (First, Middle, Last)			2.	Date of Death	Day Year	3. Time of Death
	Physici /Medio	al	FRANCIS EUGENE	RESH			07 2:	2 08	1250 ^M
1	Examir	er	4a. Facility Name (If not institution, give street and number) WMHS BRADDOCK CAMPUS		4b. City, Town, or Location			4c. County of Dea ALLEGA	
H	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)		er 24 Hrs g	Date of Birth (Month, Day, Yei	0.00	thplace (State or Foreign
	Director		21.5-36-8528	69 Yrs.	Monard Days House	Ju	(Month, Day, Yei	1939 Mai	ryland
	yland how			c. City, Town or Lo	cation				10d. Inside City Limits
	e Mar Ba-f s	Director	MD Garrett A	Accident					1 □ Yes 2 X No
	with th		10e. Street and Number		10f. Zip Code			Citizen of What Co	ountry?
	death ms 23	Funeral	575 Bowman Hill Rd. 11. Marital Status 12. Was Decedent Ever i	in U.S. 13. V	21520 Was Decedent of Hispanic Cof Yes, specify Cuban, Mexico	Origin? (Specify	Yes or No-	5A 14. Race - Ame	erican Indian,
98	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Examer must be notified at		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No		f Yes, specify Cuban, Mexica 1 □ Yes 2 1 No <i>Specif</i>		an, etc.)	Black, Whit	e, etc.
9	hours tural",	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education		dent's Usual Occupation	,	166	Specify:	White
215	hin 72 e. an "na Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done during mo DO NOT use retired)	ost of working	165.	Kind of Business	maustry
21	ed witl Ygiene Yer the	Con	10	Block	Layer			Construct	ion
and	be fill	Be	17. Father's Name (First, Middle, Last)				rst, Middle, Maid	en Surname)	
Maryland 21215-0036	shouk ind Me i mark umati	오	Galen Resh 19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	g Address (Street and Num	sie Res		y or Town, State,	Zip Code)
Ž,	is 1 and 2 is of Health a ltem 27 la other trau		Josephine I. Resh/Wife		Sowman Hill Ro	d., Acc	ident, N	1D 21520	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event inscrinual by nortified at once.				sition (Name of natory or other place)	Date		Location - City or	·
Ē	nit. Pa artmei ortant Injury e.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer® Service Licensee		Cemetery J. Name and Address of Faci	-		ittinger	
B	Department Department Important In any Ir	y //	X). Lu Jerman	1	O. Box 275, 0				P.A.
			23a. Part 1. Enter the disease, or complications that caused the canock, or hear tradure. List only one cause on each line.						Approximate Interval Between
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Lic G	vaphaco	PATH	+		Onset and Death 23 Days
7	Examiner		Due to (or es a con	sequence of);		/	/		,
	ס ב	ner	Sequentially list conditions, if any hadring to immediate cause. Enter Underlying	sequence of):					
	xecute and I-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con	requence of:					
68760,	ificate be executed physician and is the burial-transit	Sal	320 10 (0) 25 2 0011	isequence oi).					
	rtificat ng phy as the	Medical	UE CENAL C						
Вох	death certifi e attending d for use as	lan/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre	Fetal death 3	Ectopic pregnancy		3	23d. Date of de Month	livery Day Year
o	0 0 0	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time 9 ☐ Unknown 9 ☐ Unknown	of death 5	Other (specify)			Month	Day real
S, D.	law requires that the as been signed by the 2 should be detache		Part II. Other significant conditions contributing to death but not	resulting in the un	nderlying cause given in Part	11.	23e. Did tobacc	o use contribute to	the cause of death?
ord	w require	Completed by	CHOWIC OSSIPUTION	DUCK	no-lay DE	202E	1 ☐ Yes	2 5 2€No 3 □ P	robably 4 🗌 Unknown
Vital Record	0 5 0	mple	KENIE INSVERIBNICY	·	•		24a. Was an autopsy	prior to	utopsy findings available completion of cause of
Ta Ta	ilclan: The certificate h ector, page		DI ABETES MELLITUS 25. Was case referred to medical				performed 1 □ Yes 2 🔼		2 □ No
-	Physician: this certifical director.	To Be	examiner?	2 ☐ ER/Outpatien	_ Other:	ce of Death <i>(Cl</i> Nursing Home		6 ☐ Other (Spe	cify)
Division of	De Fe G	iuo i	27. Manner of Death 1 ☑ Natural 5 □ Pending 28a. Date of Injury (Month, Day, Year	28b. Time of Injury	28c. Injury at Work?	28d.	Describe how in		
/isid	Attend death ctor: y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - A	At home, farm, stre	M 1 ☐ Yes 2 ☐		ocation (Street	and Number or R	ural Route Number,
2	tal or / s after al Dire ed in b	Certification:	4 Homicide determined building, etc. (Sp	ecify)	, , , , , , , , , , , , , , , , , , , ,		City or Town, Sta		stat riddle ridiiber,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, death mination and/or inv	occurred at the time, date a vestigation, in my opinion, de	and place, and eath occurred a	due to the cause t the time, date a	e(s) and manner a and place, and due	s stated. e to the cause(s)
	within To the Comple	Mec	29b. Signature and title of certifier	1	29c. License number		29d. [Date signed (Mont	h, Day, Year)
			Frank (Kel	£ :~~	D318	75	5	36/ 2	2 2008
		Q [30. Name and address of person who completed cause of death ((Item 23a) (Type E	Print)	1. 1	1 11	1	1 215
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Si		rive, Cun	nberla	nd Ma	ry long	1 21002
	Registra	ır	JUL 2 3 2008	B A	9000			l.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** RAIFORD CHARLES EFFERY 07 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** MD TAKOMA PARK MONTGOMERY WASHINGTON ADVENTIST HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours Months 1 X M 2 □ F Director 218-50-6435 55 DEC. 18, 1952 OHIO Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 √ Yes 2 No Directo ANNE ARUNDEL MD. SEVERN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1510 EVERGREEN RD. 21144 death Funeral U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. þ Specify 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 BINDER PRINTING CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES CASS ၉ DELORIS LITTERAL. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES A. CASS/BROTHER 3767 DANUBE DR., DAVIDSONVILLE, MD. 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHAMBERS CREMATORY 7-17-2008 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A 5801 CLEVELAND AVE., RIVERDALE, MD. M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARTERIOSCLEROTIC **Physician** HEART DISEASC disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death ned by the atter detached for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 2 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pertormed? res 2 No page 1 ☐ Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2)No 1 Tes 2 ER/Outpatient ۵ 1 Inpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

32 Degistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROSS THE ND 7600

2008

7600 CARROLL AVE., TAKOMA PARK, MD. 20912

D0055918

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year **Physician** John Patrick Rainey, Jr. 15 2008 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, 24) Dove House Carrol 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 9/13/1921 215-18-9425 86 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Modical Experiment must be notified at appear. 10c. City, Town or Location 10d. Inside City Limits XXYes 2 □ No Director MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 298 Beacon Mews Ct. 21157 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status MXYes 2□No 1943-If Yes, Give 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo þ Specify: White 3 ☐ Widowed 4 ☐ Divorced 1945 Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Truck Driver Baltimore Uniform 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Patrick Rainey, Sr. Laura Pickering ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick Rainey (son) 3024 Bird View Rd. Westminster, MD 21157 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet Cem 7/22/2008 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility odd Kelln urrier-Queen Funeral Home and Crematory, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Fine) pproximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 Months Metastatic Esopha eal Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of a To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★☆ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 sl 24a. Was an autopsy XIXNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ${}_{4}\square$ Nursing Home ${}_{5}\square$ Residence ${}_{6}$ \square Other (Specify) Hospice 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3414 State

TA

larlagadda Lavanya 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MID 32 Registrar's Signature D59027

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

826 Washington Rd Ste 204 Westminster, MD 21157

JUL 1 8 2008 Compression

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - For State O	f Maryland / Department of Health and Certificate of Death	Mental Hygiene 008 24735
Physician /Medical		RAMPERSAD	2. Date of Death Month Day Year July 13, 2008 1955 M
Examiner Funeral Director	4	7. Age (in yrs. last birthday) Yrs. 4b. City, Town, or Location of Deat Cacula Lacula If Under 1 Year If Under 24 Hrs Months Days Hours Min.	Prince & corges 8. Date of Birth 9. Birthplace (State of Foreign
D	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits 1 √2 Yes 2 □ No
th with the Mar 23a or 28a-f el		BELTSVILLE 101. Zip Code PIKE 20705	10g. Citizen of What Country? TRINIDAD
.0036 hours effer death with the Maryland tural', or iteme 23a or 28a-f ehow all Examinationation or political ed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Giv	2 No 1 Yes 2 No Specify:	Specify Yes or No- to Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: ASIAN INDIAN
1215- within 72 ane. Ithan "na	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1	16a. Decedent's Usual Occupation (Give kind of work done during most of workidential) 1-4or 5+) CARPENTER	16b. Kind of Business/Industry
aryland 2 should be filed and Mental Hygie marked other umatic event, To Be Co	17. Father's Name (First, Middle, Last) RAMPERSAD R	18. Mother's Nar	me (First, Middle, Maiden Sumame) SONIAH MAHARAJ
Mar nd 2 sh lith and 27 ie m r traum	19a. Informant's Name/Relationship (Type, Print) RAMDIAL FREEDY RAMPERSAD 20a. Method of Disposition	/BROTHER 11614 OLD BALTIMORE 20b. Place of Disposition (Name of	PIKE, BELTSVILLE, MD. 20705 Date 20c. Location - City or Town, State
altimo	1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	CHAMBERS CREMATORY 7-19-	-2008 RIVERDALE, MD. HOME & CREMATORIUM, P.A.
	23a. Part1. Enter the disease, or complic flons that c shock, or heart failure. List only one cause on e Immediate Cause (Final	aused the death. Do not enter the mode of dying, such as cardiac ach line.	E., RIVERDALE, MD. 20737
Physician /Medical Examiner Examiner Examiner	Sequentially list conditions	(or as a consequence of): (or as a consequence of):	
5876(icate be physicie s the bur	d	come of pregnancy inth 2 □Fetal death 3 □Ectopic pregnancy	23d. Date of delivery Month Day Year
P.O. het the code by the detached	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to de		23e. Did tobacco use contribute to the cause of death?
* 0 - 2 E	Ene singe	heral Disease	1 Yes 2 No 3 Probably 4 HINNOWN 24a. Was an autopsy performed? performed?
Vita	25. Was case referred to medical examiner?	Othor	ath Check only one down 5 Residence 6 Other (Specify)
rattending P er death. rector: After the funeral by the funerattication;			28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
DI To the Hospital or within 24 hours afte To the Funeral Dir completely filled in Medical Cert		best of my knowledge, death occurred at the time, date and place asis of examination and/or investigation, in my opinion, death occurrer stated.	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
Within Comp	I Salvada /2	29c. License number Hroff 97	29d. Date signed (Month, Dey, Year) Tuly 16, 2006
State		e of death (Item 23a) (Type, Print) U 3001 Hosp, tal Drin egistrar's Signature	e very unplace
Registrar DHMH 17 Rev 1/2001	JUL 17 2008 /	we to foots	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $July^{Month}$ Day 2008 Year **Physician** Sharon E. Rozek 12, 9:12 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Northampton Manor Nursing Center Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🛛 F Ohio 284-38-3014 May 24. Director 1941 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show notified at 1 ☑ Yes 2 ☐ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 7067 Catalpa Rd. 21703 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene.

Is marked other than, Elementary/Secondary (0-12) College (1-4or 5+) Secretary/Administrator|Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert W. Schnell Marion Fox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) es 1 and 2 sh of Health and Item 27 is n David Rozek / Husband 7067 Catalpa Rd. Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition $\mathtt{Julv}^{ extsf{Date}} 14$. Department of Important; If It any injury or o 1 ☐ Burial 2 【ICremation 3 ☐ Removal from State Resthaven Crematory Frederick, Maryland 4 Donation 5 Other (Specify) 2008 21. Signature of Funda Service See Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the disease, or comp shock, or heart failure. List only cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Immediate C e (Final disease or indition **Physician** Due to (v as a consequence of): 1 WOPK resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and physician ar Due to (or as a consequence of) Box 68760. Physician/Medical attending p as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 ☐ Ectopic pregnancy in the past 12 months?

1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \) Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Carebra Vascular Stroke 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1□ Yes 2□ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2**X** No 1 Yes To 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) title of certifier 29c. License number 29b. Signature and 29d. Date signed (Month. Day, Year)

State Registrar 65

31. Date filed (Month, Day, Year)

10

5hay

32. Registrar's Signature

HITEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Pleas	se Type or Print				•	_	
			for State	State of Mar	yianu / L	Department of F Certificate of			0000	01707
	1.5		1. Decedent's Name (First, Middle	. Last)		Och inodic of	Douin	Reg. 2. Date of Death	No. 200}	3. Time of Death
	Physici		Helen	Snieciensk	1			Month July	Day Year 2008	6:16 A.M
	/Medic Examin		4a. Facility Name (If not institution	, give street and number)	. ,	4b. City, Town, o	r Location of Death	/ /	4c. County of Dear	th
, A			Western Maryland	Health System Bi	Addock CA	mous Cumb	perland		Allegan	14
	Funeral		5. Social Security Number	6. Sex 7. Age 1	(In yrs. last bir	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Co	thplace (State or Foreign
E	Director		Usual Residence of Decedent	18 18 2941	6.5	Yrs.		August 26, 1	942 MA	Mande
	fand ow at		10a. State 10b. County		10c. City, Tow	n or Location		·····		10d. Inside City Limits
	Many Firsh	io	Maryland Alley	a NU	FROS	thurg				1 X Yes 2 □ No
	or 28a	Director				10f. Zip Code		10g.	Citizen of What Co	ountry?
	n 72 hours after death with the Manyland "natural", or Items 23a or 28a-f show • Itea Examiner must be notified at		One Knylox	Circle		2153.	2		45A	
	tems	Funeral	11. Marital Status		er in U.S.	13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	s afte	by F	1 ☐ Never Married 2 ☐ Marri 3 🕱 Widowed 4 ☐ Divorced	ied Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:)	1 ☐ Yes 2 ☑ No	Specify:		Specify: W	hitp
5-0036	tural sal Es	edk	15. Decedent			Decedent's Usual Occup	pation	166	. Kind of Business	
ر د	within 72 ho iene. than "natui he Me ical	Completed	(Specify only highes Elementary/Secondary (0-12)			(Give kind of work done life. DO NOT use retire	during most of work	ing		,
7	d with giene er tha	ĕ	12	Out. 0 (1 401 01)	<u> </u>	Nurse Assi	stant		Nursing	Ĵ
2	be file	Be (17. Father's Name (First, Middle,				_	e (First, Middle, Mai	den Surname)	
<u>X</u>	Meni Meni arke	ည		Crawford			Beula			
<u>a</u>	12 sh h and 7 Is m traum		19a. Informant's Name/Relations			. Mailing Address (Street			ty or Town, State,	Zip Code)
e,	1 and Healt em 27		Jeffney W. A 20a. Method of Disposition	e45e - 50n	20b. Place of	10 Scenic La Disposition (Name of	ne, Jeve	Pate 200	. Location - City or	49/)/
ē	ages int of t: If its		1 M Burial 2 ☐ Cremation		cemete	ry, crematory or other pla ew Cemet	ce)	. 4 41	-	1
altimor	permit. Pac Department Important: any injury once.		4 Donation 5 Dother (S ₁ 21. Signature of Funeral Service	-	1017. 01	22. Name and Addre		7 0 70	03000/111	11s, Maryland
ñ	Dep Imp		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Ken i		Eichhorn-Mck	•	1 Home P.A.	Lengennin	10 Maryland
			23a, Part1, Enter the disease, or	complications that caused the	he death. Do					Approximate
7	Physician	k q	Immediate Cause (Final disease or condition	only one cause on each line		ARREST				Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a		of):				
	Examiner		So wentially list conditions	b. CARD	IAC	ARRYTA	mus			1 Hour
	D #8	iner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its lead to the cause)	Due to (or as a	consequence	ot):				
	be executed ician and burial-transii	Examin	that initiated events resulting in death) Last	c Due to (or as a	concomuence	of)-				
Ď,		ial E		Due to (or as a	consequence	01).				
2	death certificate e attending phys d for use as the			d						
XOX	certii nding use a	Physician/Media	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pt					23d. Date of de	livery
ň	death atte	icial	in the past 12 months? 1 ☐ Yes 2 🕱 No	1 ☐Live birth 2 4 ☐ Pregnant at ti		3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		Month	Day Year
J.	nt the by the tache	hys	9 Unknown	9□Unknown						
_	law requires that the as been signed by th 2 should be detache	by F	Part II. Other significant condition	HRONIC O	not resulting in	the underlying cause giv	ren in Part I.	. 1		o the cause of death?
Hecords,	equir sen si ould	ted	JEVDICO O	20012 0	P3 / W C	CLIVE J.	DIGGIST	Y 1□ Yes	2 No 3 P	robably 4 🖫 Únknown
ပ္ပ	law r las be	Completed	OBESILY	70 10			VISEASE	24a. Was an autopsy	l prior to	utopsy findings available completion of cause of
_	: The	ပ္ပ	DIABELES	Melli lus				performed 1 Yes 2 ₹	death? No 1 ☐ Yes	s 2 □ No
VII	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:		tratiant 317 DOA Oth		h (Check only one)		
ō	Phys this ral dir	년 -	1 ☐ Yes 2 ☑ ∕No 27. Manper of Death	1 ☐ Inpatient		ipatient SI DOA	4 LI Nursing Ho	me 5 Residence		ecify)
	ding h. After funer	ion	1 ☑ Natural 5 ☐ Pending	g (Month, Day	Year)	njury Wo	rk? Yes 2 □ No	200. Describe flow i	njury occurred	
UIVISION	Atten deat	fica	3 Suicide 6 Could r	not be 28e. Place of injury	J y - At home, fa	rm, street, factory, office		28f. Location (Stree	t and Number or H	ural Route Number,
5	al or safter	Certification:	4 ☐ Homicide determ	building, etc.	(Specify)			Cify or Town, S	tate)	
	ospit hours unera	Sal C	29a. Certifier 1 Certifyin	g Physician: To the best of Examiner: On the basis of e	my knowledge	e, death occurred at the ti	me, date and place,	and due to the caus	e(s) and manner a	s stated.
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director, After this certifical completely filled in by the funeral director,	edical	one)	and manner state						
	with con	Σ	29b. Signature and title of certifier	~		29c. Licens	r / 2 0	29d.	Date signed (Mon	th, Day, Year)
		P		mgn (S		1 4 7	2020		my 11	, 2008
		0	30. Name and address of person SATURNINA Ct	who completed cause of dea HANG M.D. 4	atn (Item 23a)	(Type, Print)	of Ahura	Marylo	mil =	1,532
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1	-1000	1 -00 -100	, 01	
L	Registr	rar	JUL 1	8 2008	e Me	Anni :				

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ORIGINAL

				pe or Print in B State of Maryland							egible.	
		,	For State Registrar	,	-	tificate of			-	Reg. No.	2000	21.720
П			Decedent's Name (First, Middle, Last)		-			2	2. Date of De Month	ath	2 U U O	3. Time of Death
	Physici /Medio		BRUCE KENNETH	SWEITZER JR	•			(07	_18	2008	1442 P M
į.	Examin		4a. Facility Name (If not institution, give sti	eet and number)		4b. City, Town, o	r Location o	of Death		4c. (County of Death	
-	and the second		MEMORIAL CAMPUS	T		CUMBERT If Under 1 Year		O4 Um La	D / (D)		LEGANY	
\$2. **	Funeral Director		5. Social Security Number 6. Sex 220–38–2361 Usual Residence of Decedent	7. Age (In yrs. la	Yrs.	Months Days	Hours	Min.	B. Date of Bir (Month, Date 1	y, Year)	Cou	place (State or Foreign ntry) yland
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	ctor	10a. State 10b. County MD Garrett	_	Town or Locanton	cation						10d. Inside City Limits 1 ☐ Yes 2 No
	or 28)ire	10e. Street and Number			10f. Zip Code				10g. Citiz	en of What Cou	ntry?
	ath w	ra	2145 N. Glade Road			21561					ted Sta	
36	s after de	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	N. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Vees, Flories.	l1	Vas Decedent of H FYes, specify Cub ☐ Yes 2 X No	lispanic Ori an, Mexicar Specify:	n, Puerto R	ify Yes or No ican, etc.)		4. Race - Ameri Black, White Specify:	, etc.
Ş	hour Itural	ed b	15. Decedent's Educa	Year or Dates:	16a. Deced	ent's Usual Occur	oation			16b. Kir	Wh nd of Business/li	ite
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Be Completed	(Specify only highest grade: Elementary/Secondary (0-12) 12		(Give l life. E	kind of work done 00 NOT use retire oorer		st of working	9		eghany.	•
ַם	e filed Il Hyg other	e C	17. Father's Name (First, Middle, Last)	'			18. Mothe	er's Name (First, Middle			
<u>Ja</u>	uld be Ments wrked wrice	To E	Bruce Sweitzer Sr.				Lyd	lia As	sh			
Maryland	2 sho and I Is ma		19a. Informant's Name/Relationship (Type	•	19b. Mailin	g Address (Street	and Numb	er or Rural	Route Numb	er, City or	Town, State, Z	ip Code)
2`	and 2 lealth a m 27 ls her tra		Barbara Sweitzer,			N. Glade						
Baltimore,	ges 1 t of H if itel		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State 20b. Pla	ace of Dispos metery, cren	sition (Name of natory or other pla	ce)	Da	te	20c. Loc	cation - City or T	own, State
	t. Partmen tant:		4 □ Donation 5 □ Other (Specify)	-		Cemetey		//22/0			nton, M	D
g	permi Depar Impor any Ir		21. Signature of Funeral Service Licenses		22	Name and Addre David A.	Burd	lock F	uneral	LHom	e, P.A.	
			23a Part 1 Enter the disease or complic	ations that caused the death	Do not ente	21 N. Se					D 21550	Approximate
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.		or the mode of dyn	ng, such as	outdiac of	respiratory a	irredt,		Interval Between Onset and Death
7	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	O W L	opath	y no	n i	schen n	ne.	-	
oʻ	cate be executed chysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due tollor as a conseque	ence of):	/1 //		mslo	n '			
08/PU	ificate be e g physician as the buria	edical	d.	OUSTY	uctm	re Ster	ep.	apr	1001			
.O. Box	uires that the death certificate be signed by the attending physicia d be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome pf pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□	Ectopic pregnanc Other (specify)	у			2	3d. Date of deli Month	very Day Year
ري ح	requires that the een signed by th nould be detache	by Pi	Part II. Other significant conditions cont	ributing to death but not resul	ting in the ur	nderlying cause giv	ven in Part 1	1.	23e. Did	tobacco u	se contribute to	the cause of death?
ğ	w require been sig should b	ed b	Ctf.	- n +					10	Yes 2]No 3∏Pro	bably 4 Unknown
ည္ပ	law asb 2sb	Completed	Diahetess	nellitus'					24a. Was		24b. Were au	topsy findings available ompletion of cause of
Ĭ	The ate h page	E O							perfe	ormed?	death?	2⊠ No
or vital Records,	iclan: Th certificate ector, pag	Be (25. Was case referred to medical examiner?				26. Píace	e of Death	(Check only		1	
		2	1 ☐ Yes 2 🗖 No		R/Outpatien		4 ⊔ Ni		-		G □Other (Spec	rify)
<u></u>		on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo			3d. Describe	how injury	y occurred	
Uivision	Attendest death cctor; y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hor building, etc. (Specify	me, farm, str		Yes 2		3f. Location (City or To	Street and wn, State,	d Number or Ru)	ral Route Number,
-	To the Hospital or Atten within 24 hours after deatl To the Funeral Director; completely filled in by the	ledical Ce	29a. Certifier (Check only one) 1 A Certifying Physical Examin	cian: To the best of my knov er: On the basis of examinati and manner stated.	vledge, death ion and/or in	n occurred at the tivestigation, in my	ime, date a opinion, de	nd place, a ath occurre	nd due to the d at the time	cause(s) , date and	and manner as I place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number			29d. Dat	e signed (Month	n, Day, Year)
)			MAJaice	n, MD		D0066	150			0	1/18/0	8 15-30
			30. Name and address of person who cor	pleted cause of death (Item	23a) (Type,		1 1 10	1000		-0.0	1	
		10	325 Kent Ave	Sut 204 (? cesule	Or Lanc	* MY	121	102	1		
	Sta Regista		31. Date filed (Month, Day, Year)	32. Régistrar's Signat	The state of	and o						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 24739

James Hubert Spe	1-	er, Jr. For State egistrar	State	of Maryland	/ Depart <i>Certi</i>	tment of ficate of	Health and Death	d Mental F	Re	g. N o.	200	18 24/3
Physician/	1	Decedent's Name							2. Date of Deat Month July 21, 20	Day Ye	ear	3. Time of Death 1330 hrs
Medical Examine				eicher, Jr		14	b. City, Town, or	Location of Deat		4c. County	y of Death	100010
,	4	218 Short M	_	e street and trambor,			Friendsville			Garrett		
Funeral	5	. Social Security N	umber 6. S	ex 7. Ag	e (In yrs. las	t birthday)	If Under 1 Yea			h(MM/DD/YY)	Foreign	nplace (State or
Director		215-80-4	808 15	M 2 F		38 Yrs.	Months Day	S Hours W	Oct. 1	5, 196	9 Cour	ntry)Maryland
,	_	sual Residence of 0a. State	Decedent 10b. County		10c. City, T	own or Locati	on					10d. Inside City Limits
now any		MD	Garre	++		ndsvil						1 Yes 2 X No
a or 28a-f sh	<u> </u>	0e. Street and Nur			1220	11000 1 = -	10f. Zip Code		1	0g. Citizen of V	What Count	try?
the M a or 2 tiffed	<u> </u>	218 Shor	t Mile R	d.			21531			USA		
Figure 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The Train of the stand other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.		Marital Status Never Marris	ed 2 X Marrie	12. Was Deceden Armed Forces		. 13. Wa	s Decedent of Hi es, specify Cuba	spanic Origin? (: n, M exican, Puer	Specify Yes or No to Rican, etc.)		ice - Americ hite, etc.	can Indian, Black,
or deat	[[Never Marrie Widowed		1 Yes 2 d If Yes, Give Year	X No	1	Yes 2 X No	specify:		Specify	y: Wh	nite
urs afte	∂⊢	_		or Dates: only highest grade co	mpleted)	16a, Deceden	it's Usual Occupa	ation (Give kind o	f work done	16b. Kind of		
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within iene.		12 7. Father's Name	(First Middle Los	4\		Insta	ller	18 Mother's Nar	me (First, Middle,	Carpe Maiden Surnar		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	اه			icher, Sr				Verna B	·			
212 ould by Ment it ever		19a. Informant's Na	me/Relationship	Type, Print)					r Rural Route Nur			1
MD id 2 shoulth and m 27 is aumati				her/Wife	Look D		hort Mil		Friendsv			1531 Town, State
ore, es 1 an of Hea		20a. Method of Dis 1 X Burial 2		Removal from S	itate Cr	rematory or ot	her place)		y 25, 20	1	•	
Baltimore, permit Pages 1 ar Department of He- Important: If He- injury or other tr		4 Donation 5	Other Specifical Lice		Duc	st Cem		1	wman Fun			
Baltimo permit Page Department of Important: Injury or oth		21. Signature of Fit		mo				_	ntsville		21536	
Physician	Ţ		ne disease, or cor nly one cause on	plications that cause	d the death.	Do not enter	the mode of dying	g, such as cardia	c or respiratory ar	rest, shock, or	heart	Approximate Interval Between Onset and
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Xammer	-	or condition resulti		Due to (or as a con	sequence of):						
	اةِ	Sequentially list co if any, leading to in	nmediate	Due to (or as a con	sequence of):						
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uted nd ransit		events resulting in	uealii) Last	d								
t0, e be executed ysician and burial - transit	edical	UNPENDED		AMENDED								
Box 68760, he death certificate be executed by the attending physician and hed for use as the burial - transit	§ .	IF FEMALE: 23b. Was deceden	t pregnant in the	23c. If yes, outc	ome of pregr		etal death 3	Ectopic pre	gnancy	23d. Date Mont	e of deliver	y Day Year
Box 6876(he death certificate the attending phy, hed for use as the be	sician/M	past 12 month	,	4 Pregnant	at time of de	ath 5 C	Other (Specify)					9
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in the funeral director.	Phys	1 Yes 2 Part II. Other sign		9 UIKIOWII	ath but not re	eculting in the	underlying cause	e given in Part I.	23e. Did	tobacco use o	ontribute to	the cause of death?
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	ᅙ	Part II. Other sigr	inicani condition	s contributing to de	atti but not re	ssuning in the	underlying dadd	5 giroir iii - aic ii	1 _ Y	es 2 🗸 No	3 Pro	bably 4 Unknown
ds, l	ed led		· · · · · · · · · · · · · · · · · · ·						24a. Wa			utopsy findings available completion of cause of
COF	Completed									opsy formed? 2 No	death?	_
Re Ithe Ithe Ithe Ithe Ithe		25. Was case refe	rred to medical	<u> </u>			26.Pla	ice of Death (Che				
Vita ystcian ystcian his cer directe	o Be	examiner?	2 No	Hospital: 1 Inpa	tient 2	ER/Outpatier	nt 3 DOA	Other ₄ Nu	rsing Home 5	Residence		ar: Scene
of \ng Phy	-1	27. Manner of Dea	ath	28a. Date of I (Month, Da	njury y,Year)	28b. Time of	,	njury at Work?	28d. Describ	e how injury of	curred	
tendi tendi death.	읉	1 Natural 2 Accident	5 Pending	ation		<u> </u>		Yes 2 No	20f Location	(Street and N	lumber or R	dural Route Number, City
Divisior ospital or Attend hours after death, uneral Director: y filled in by the	Certification:	3 Suicide	6 Could r	ot be	Injury - At h	ome, tarm, str	eet, factory, office	e building, etc.	or Town		diffici of 10	arar reason ramber, only
Lospita 4 hours unera		4 Homicide	Cortifuing Phys	vision: To the best of	mv knowled	ge, death occ	urred at the time,	date and place,	and due to the ca	use(s) and ma	inner as sta	ated.
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach.	Medical	(Check only one) 2 ✓	Medical Exami	ner:On the basis of e and manner state	xamination a	and/or investig	ation, in my opini	ion, death occurr	ed at the time, da	te and place, a	ind due to t	he cause(s)
F. N. F. 8	ŝ	29b. Signature an	d title of certifier	and manner stars				ense number		1	,	onth, Day, Year)
		Da	-m li	ol , MP			0.0	C.M.E. 		July 22	, 2008	
/	ړ			Assistant Me			11 Penn Stre	et. Baltimore	. MD 21201			
Sta	<i>(</i>	31. Date filed (Mo	Vincenti, MD		trar's Signati				,			
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		-	State of Maryland / Department of Health and Mental Hygiene 2000 247 740 State	
	Dhysisis		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death	
	Physicia /Medic		GAGE LOUIS SALVATORE JULY 11 2008 6:30 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	_
1	Examin	er	St. Joseph Medical Center Towson Baltimore County	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Months) Days Hours Min (Months) Country).	1
	Director		Usual Residence of Decedent	_
	show	5	Tod. State	
	r 28a-f	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	_
	th with		1610 Rushing Stream Court 21050 USA	_
	items items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Hace - American Indian, Black, White, etc.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Extrainment or notified at once.	þ	3 □ Wildowed 4 □ Divorced If Yes, Give Year or Dates:	
15-0	"natur	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
212	y withir giene.	omo	Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFANT	
pu	be filed tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
<u> </u>	hould Id Men marke matic	မ	Michael Bryan Salvatere Alison Lee Cole/Io 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	_
Ma	alth ar 27 is		michael + Alison Salvatore (PARENTS) 1610 Rushing Stream Court Forest Hill, MARYland 21050	
Baltimore,	ges 1 at of He If Item or other		20b Mathed of Disposition Date 20c Location - City or Town, State	
Ħ,	artmen artmen ortant: injury		1 MBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Although State Complex State Complex State Complex State Complex State Complex State Complex State Complex Co	
Ba	Depril Impe		St. Joseph Medical Center Towson, Md. 21264	
			23a Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death	
i.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Severe Rematurity Due to (or as a consequence of):	3,
	Examiner			
	pa tis	iner	Sequentially list conditions, if any, leading to immediate course. E. Arth Ut de-thing. Cause (Disease or injury	
	executi n and al-tran	Examiner	Cause (clisease of injury that initiated events resulting in death) Last Due to (or as a consequence of):	
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical	d	
	certifica ding pl		IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
. Box	The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	
P.O.	at the d by th etache	Phys	9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
ds,	s law requires that the di has been signed by the e 2 should be detached	d by	1 Yes 2 No 3 Probably 4 Unknown	n
000	aw req as beer 2 shou	Completed	24a. Was an autopsy prior to completion of cause of	e
E E		Com	performed? death? 1 □Yes 2 □No 1 □Yes 2 □No	
Vita	Physician: The ribis certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 No	-
Division of Vital Records,	g Physter this	n:To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
sior	Attending ir death. ector: After by the fune	catio	2 Accident investigation M 1 Yes 2 No	
Divi	Jor At after d Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
	o the Pitthin 24 o the Pomplet	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	_
	⊢ ≯ ⊢ ō		Quettani Jem, MD 030622 7/15/2008	
	K.H		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 OSIER DRIVE SUITE 402	
	Sta	ite	RUTHANN ZERN MD O'DEA Medical Arts Bldg. Towsow, MARYland 21204 31. Date filed (Month, Day, Year) 4 2000 32. Hegistrar's Signature	_
	Regist		JUL 3 I 2000 NOTES	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 21 per FH 881 / 31/08 0k Reg. No. 1 - For State Registrar Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** VIV Nancy Stephens 17:13 2008 oretta /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** County General Hosp Howard Howard 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2**½** F Yrs. October8,1911 New York 96 Director 195-03-8904 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Injury or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evanine must be notified at once. 1 ☐ Yes X☐ No Directo Ellicott City Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . A. 2942 Rosemar Drive 21043 U.S Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White ģ 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena M. Youker Grover C. Smith 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 Oak Shadows Court, Catonsville, Maryland Betty Lou Pulling 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 21 - 08Hill Cemetery 4 Donation 5 Dother (Specify) Laurel Erie, Pennsylvania 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M00407 Marzullo Funeral Chapel, P. A. Michael P. Marzullo per DVR 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septic /Medical Due to (or as a consequence of): **Examiner** Diverticulities lweek Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a I be detached f Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 No 3 Probably 4 Unknown 1 🗌 Yes After this certificate has been si funeral director, page 2 should? Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2. ER/Outpatient 3 ☐ DOA Certification: To 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t spital or Attending Phours after death.
neral Director: After ty filled in by the funera 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) MD2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Riesell MD MD 21044 Columbia 10700 Charter 31. Date filed (Month, Day 32. Registrar's Signature Year) State JUL 3 2008

DHMH 17 Rev 1/2001

Registrar

Call Marie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death J_{u1y}^{Month} 20, 2008Year **Physician** 11:45 A M Ethel Cleo Sparks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 20562 Adkins Road St. Mary's Lexington Park If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Funeral Davs Hours 1 ☐ M 2 🖾 F 217-42-7893 77 Virginia October 30, 1930 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County 28a-f show r than "natural", or items 23a or 28a-f showns the Medical Evanither must be notified at 1 ☐Yes 27 No Director Maryland St. Mary's Lexington Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20562 Adkins Road 20653 USA Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 ☒ No 11. Marital Status Black, White, etc. 1 Never Married 2X Married Specify: White Maryland 21215-0036 1 ☐ Yes 2K No If Yes, Give à 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Pages 1 and 2 should be filed went of Health and Mental Hyginnt: If Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dallas N. Sellers Bertie Moore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health at Important: If Item 27 is any Injury or other trau 20562 Adkins Road Lexington Park, MD 20653 George Sparks / Husband Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State July 24 Leonardtown, Maryland Charles Memorial Gardens 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenseq Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. | detached 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Myocardial Infarction, Stroke icate has been si , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ₹ No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 \ Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 TI Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D55682 July 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Wilkinson, MD 23130 Moakley Street Leonardtown, MD 20650 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 2 3 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Mary	rland / Depa			nd Menta	Hygie	ne No. 200	3 2474
,	Physici /Medic		1. Decedent's Name (First, Middle, La Omie Elizabeth	Swenton		1		July	e of Death	2008 Year	3. Time of Death
F	Examir Funeral	ner -		ital	n yrs. last birthday) 7 Yrs.			3	e of Birth onth, Day, Ye	4c. County of Dea Montgome 9. Bir 25, 1930	ry
D	woys -	tor	416-40-0572 Usual Residence of Decedent 10a. State 10b. County Maryland Prince		c. City, Town or Lo		e			23,1750	10d. Inside City Limits
with the	3a or 28a at be notif	Funeral Director	10e. Street and Number 5619 31st Avenue	2		10f. Zip Code 207)		10g.	Citizen of What Co	ountry?
d 21215-0036 filed within 72 hours after death with the Maryland	Department or neatin and wentar rygene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Madical Examination at ance. Once.		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		Was Decedent o If Yes, specify Cu 1 □Yes 2 N		n? (Specify Ye Puerto Rican, (s or No- etc.)	14. Race - Am Black, Whit Specify:	
Maryland 21215-0036	grene. er than "natu , the Mudical	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use reti maker	e durina most o	of working	161	At Home	/Industry
Taryland 2 should be file	narked other	To Be (17. Father's Name (First, Middle, Last Ashford Bassham				Lia	zzy Rob	ertso		
Tand 2 sh	em 27 is in ther traum		19a. Informant's Name/Relationship Jeanette S. Mukta 20a. Method of Disposition	/daughter		Prospe			arlot	te Hall, Location - City or	MD 20622
Baltimore,	ortant: If it ortant: If it injury or o		1 ⊠Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice	Removal from State (fy)	cemetery, crer Queen of	natory or other p	emetery	July 2	5,200	8 Helen,	
B F	impo any ir		23a. Part 1. Errer the disease, or con	& Demo	08/7 3	0195 Th:	ree Not	ch Rd.,			Approximate
/M Exa	ysician ledical aminer	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or Injury that initiated events	b. Pneumor Due to (or as a cc	nia						Interval Between Onset and Death Days Days
of Vital Records, P.O. Box 68760, Physician: The law requires that the death certificate be executed	ne attending physician and ed for use as the burlal-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as a co	regnancy	☐ Ectopic pregna				23d. Date of de Month	olivery Day Year
'ds, P.C	n signed by the Id be detached	ğ	9 ☐ Unknown Part II. Other significant conditions		ot resulting in the u	nderlying cause	given in Part I.	23			o the cause of death?
al Records,	certificate has been s'ector, page 2 should l	Completed						_ _	a. Was an autopsy performed Yes 2 2	prior to death?	utopsy findings available completion of cause of s 2 No
of Vital Physician: T	gi se.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 █ No	Hospital: 1 Hospital	2 ER/Outpatier	nt 3 DOA	Other:	of Death (Checosing Home 5		e 6 □Other (Spe	ecify)
E g	To the Funeral Director: After the completely filled in by the funeral	Certification:	27. Manner of Death 1 Synatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	De Place of Injury	At home, farm, str	M 1	□Yes 2□No	28f. Loc		injury occurred et and Number or Fi state)	ural Route Number,
e Hospita	le Funeral	Medical C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of m miner: On the basis of ex and manner stated	amination and/or in	h occurred at the vestigation, in m	e time, date and y opinion, death	place, and du occurred at th	e to the cause time, date	se(s) and manner a and place, and du	as stated. e to the cause(s)
To th	To th	Me	3 ame and address of person who			D-3	ense number 32332		29d	Date signed (Mon	
	Sta Registr		Suresh Gupta, M	32. Registrar's		ver Spr	ing, MD				

08-05578 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Shiela Staycoff 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 21, 2008 1340 hrs **Medical Examiner** Sheila Renee Staycoff 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Saint Leonard Calvert 5002 Harvard Street Date of Birth (MM/DD/YYYY)Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Country) Days Hours Min Months Director Illinois 1 M 2X F 18, 1967 341-72-2480 40 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State Yes 2 X No or items 23a or 28a-f show must be notified at once. Calvert County St. Leonard MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5002 Harvard St. 20685 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black Funeral 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married 2 X No Yes is marked other than "natural", or afte event, the Medical Examiner mu Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural", of injury or other tranumatic event, the Medical Examiner in injury or other tranumatic event, the Medical Examiner in the state of the control of the con Specify: White If Yes, Give Year or Dates: 1 Yes 2 X No specify: Widowed 4 X Divorced ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Samuel Staycoff Sara Counts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 45269 Clarke's Landing Rd., Hollywood, MD 20636 Shannon M. Staycoff (Daughter) 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a Method of Disposition July 24crematory or other place) Burial 2 X Cremation 2008 Clinton, Maryland Lee Crematory Donation 5 Other Specify. 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Funeral Service Licenses 8125 Southern Maryland Blvd., Owings, MD 20736 Michael W. Lee, per DVR 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examine Lause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical $\overline{\mathbf{X}}$ AMENDED #1,23a,PII,27,perME, 21,perFD G882 8/11/08 TT X UNPENDED ending physician use as the burial Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 🗸 Unknown 9 Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö à 1 Yes 2 No 3 Probably 4 V Unknown σ. Chronic obstructive pulmonary disease Completed Records, 24a. Was an 24b. Were autopsy findings available has been autopsy prior to completion of cause of performed? death? page 2 2 No ✓ Yes 2 1 🗸 Yes certificate 26 Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medica funeral director, Division of Vital Be Other₄ examiner? Hospital: DOA Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 V Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1**X** n 24 hours after death.

The Funeral Director: A pletely filled in by the fun Natural Yes 2 No Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 1, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Russell Alexander MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DOME Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15 2008 0250 July Leon Smith 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Year) 932 1**∑**M 2□ F Months Days Hours Min Maryland 214-26-3008 76 Yrs. July Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 USA 12 Silopanna 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 √Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th 0 Truck Driver Kotzin Dailev 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hattie Pindell Waverly Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1265 Lower Pindell Rd. Sheila Smith (Daughter) Lothian, Md. 20711 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemeters, breinatory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 7-21-08 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Miname Accordence of Scill Sons Mortuary, 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. D. Been MCOY8 arry 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aecu disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to seath but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Maa Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes P ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

Department of Health and Mental Hygiene. Input and the state of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination at the notified at once.

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

the Maryland

/Medical

Director

Funeral

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Completed

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and burial-tran attending physician the as for use the detached signed by 1 1 be detach peen has this

P.O. Box 68760,

Division of Vital Records,

Physician/Medical ۾ Completed funeral director, Be After t

Examiner

2 Accident

3 Suicide

4 Homicide

(Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed Medical Certification: To n 24 hours after death.

The Funeral Director: A pletely filled in by the fu 29a. Certifier completely To the within 2. 29b. Signature 31. Date filed (Month, Day,

State Registrar

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Amapois, Md

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hopra Meclica

Year) 1 6 2008 JUL

6 ☐ Could not be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. Division of Vital Records, P.O. Box 68760,

For State		State of	Marylan		rtment of F tificate of I		Mental Hy	•	200	38	2474	
1. Decedent's Nam	ne (First, Middle, La	nst)			inouto or i		2. Date of De			3. Ti	me of Death	
Wilda K	athryn Sl	hafer					July	Day 11	200	9:0	5 P M	
	If not institution, given	ve street and numb	er)	4b. City, Town, or Location of Death 4c. County of D								
	.ck Memor:					erick			Frederick			
5. Social Security N 220–40–0	530	Sex 7. 1 □ M 2 □ x F	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		av. Year)	C	thplace (Sountry) Land	State or Foreign	
Usual Residence of	10b. County		10c. City	, Town or Loc	ation					10d. Ins	ide City Limits	
Maryland	Freder	ick	Fre	derick							Yes 2 No	
Maryland 10e. Street and Nu					10f. Zip Code			10g. Citiz	en of What Co	untry?		
	dwick Co	urt			2170	2		US	SA			
11. Marital Status 1 Never Marital Status	ried 2 Married	12. Was Deceded Armed Force 1 Yes 2 If Yes, Give Year or Date	es? X No		Vas Decedent of H Yes, specify Cuba □Yes 2 ½ No	ispanic Origin? (S in, Mexican, Puerl Specify:	Specify Yes or No to Rican, etc.)		4. Race - Ame Black, White Specify:		•	
	15. Decedent's E	ducation	rking	16b. Kin	d of Business	/Industry						
Elementary/Sec	ondary (0-12)	College (1-4	or 5+)	Beaut	kind of work done o OO NOT use retired ician	"		Bea	uty			
17. Father's Name	(First, Middle, Las	t)				18. Mother's Nar	ne (First, Middle	, Maiden S	Gurname)			
Willard	S. Holte	r				Kathr	yn Zimme	rman				
19a. informant's N	lame/Relationship		ıd		g Address (Street Sedwick					Zip Code) 217		
	sposition Cremation 3 [5 Other (Speci			lace of Disposemetery, crem	sition (Name of natory or other place formed		Date -2008		ation - City or			
	uneral Service Lice		A	7	Name and Addre		Stauffe ike, Fre				d 2170	
Immediate Cause (Final disease or condition resulting in death) a. Methstatric lung Nodules Due to (or as a consequence of): Waliquant Leffusion, bilateral Due to (or as a consequence of): Chondro Shrows Due to (or as a consequence of): Chondro Shrows Due to (or as a consequence of): Chondro Shrows Due to (or as a consequence of):												
IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown Part II. Other sign	2 months?		th 2 Detail nt at time of d	death 3	Ectopic pregnanc	у		2:	3d. Date of de	elivery Day	Year	
Part II. Other sign	ificant conditions	contributing to dea	th but not resu	ulting in the ur	iderlying cause giv	en in Part I.			se contribute t		se of death?	
							24a. Was auto perf	an opsy ormed?	24b. Were a prior to death?	utopsy fin completic	dings available on of cause of	
25. Was case refe	erred to medical					26. Place of Dea	1 ☐ Yes ath (Check only	2 ½ No one)	ı ∐ Ye	s 2□N	· · · · · · · · · · · · · · · · · · ·	
	ĭ .No	Hospital: 1 Zinj	oatient 2 🗆	ER/Outpatien	t 3 DOA Oth	er: 4 \(\sum \) Nursing H	Home 5 ☐ Res	idence 6	Other (Sp.	ecify)		
27. Manner of Dea 1 Natural 2 Accident	5 ☐ Pending investigation	on	Injury Day, Year)	28b. Time of Injury	Wor	y at ⟨? Yes 2 □No	28d. Describe	how injury	occurred			
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		f Injury - At ho , etc. <i>(Sp</i> ecify	me, farm, stre	eet, factory, office		28f. Location City or To	(Street and wn, State)	Number or F	lural Rout	e Number,	
1 Yes 2 Z 27. Manner of Dea 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	1 ☐ Certifying P 2 ☐ Medical Exa	hysician: To the bandiner: On the base	is of examina	wledge, death tion and/or in	occurred at the tivestigation, in my	me, date and place pinion, death occ	e, and due to the urred at the time	e cause(s) , date and	and manner a place, and du	as stated. e to the ca	ause(s)	
29b. Signature and			0/		29c. Licens				signed (Mon		_	
	d title of certifier	Le.	10 an		MDD3	2100		1/	13/	200	00	
30. Name and add Myung Hee	ress of person who						and 217		13/	200	00	

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Regis DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

			Plea	se Type or Pri						•	
	-	For State		State of iv	ıaryıan		artment of F rtificate of	Health and M		giene Reg. No. 2008	3 24747
		Registrar 1. Decedent's Name	e (First, Middle	e, Last)			inoate or	Douin	2. Date of Dea		3. Time of Death
Physicia		Otis (Clevela	and Spicer					Month JULY	Day Year	3 4:00 AM
/Medic Examin		4a. Facility Name (/	If not institution	n, give street and number		zer	4b. City, Town, o	or Location of Death	73	4c. County of Dea	
Funeral Director		5. Social Security N		6. Sex 7. A	ge (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da June 1	y, Year) 0.26 C	rthplace (State or Foreign ountry)
ъ	1	Usual Residence of	f Decedent				L			VI	3
arylar show		10a. State	10b. County		10c. Cit	y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
the M	Funeral Director	MD 10e. Street and Nur		timore		Freela	10f. Zip Code			10g. Citizen of What C	
with with				Mill Road			Tot. Zip code	21053		USA	outiny:
death	nera	11. Marital Status		12. Was Deceden		S. 13.	Was Decedent of I	Hispanic Origin? (Sp	ecify Yes or No	- 14. Race - Am	
after or ite		1 Never Marr		If Yes Give			irves, specify Cub 1 ⊡Yes 2 ⊡ X o		Hican, etc.)	Connectifier	
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ont, its Mydical Exaction from the mylified at	od be	3 Widowed		Year or Dates							White
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ould b I Ment parked	၉	Clarenc							e Tuel		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it would be not inversely be notified at once.		19a. Informant's N					,	t and Number or Rur O Taverns		er, City or Town, State, ettysburg,	
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mit. F partm sortar / Injur	1	21. Signature of Fu		*	_JCdI					Hampstead, hapel, P.A	
permi Depa Impo any Ir		John	LKF	4802						minster, M	
Physician		23a. Part. Enter t shock, or hea Immediate Cause disease or condition	art failure, List (Final	complications that cause only one cause on each	line.		er the mode of dyi	ing, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)		Due to (or a	s a conseq	uence of):					
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or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE:		00-14							
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siclan certifi rector	Be	25. Was case refer examiner?	_	Hospital:			Ott	26. Place of Deat			
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ndlng ath. :: Afte e fune	atio	1 ✓ Natural 2 ☐ Accident	5 ☐ Pendin investi		ay, Year)	Injury		rḱ?]Yes 2 □ No		,,	
r Atte er dea rector by th	ti tic	3 ☐ Suicide 4 ☐ Homicide	6 □ Could determ	not be 28e. Place of li building, e	njury - At ho	ome, farm, str fv)	eet, factory, office	-	28f. Location (: City or Tou	Street and Number or F	Rural Route Number,
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Medical	29a. Certifier (Check only one)	1 Certifyir 2 Medical	ng Physician: To the bes Examiner: On the basis and manners	of examina	owledge, deat ation and/or in	h occurred at the t vestigation, in my	time, date and place opinion, death occur	and due to the red at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)
Vithi Comp	M	29b. Signature and	title of certifie	, b Wa	Alia	mo		se number		29d. Date signed (Mor	nth, Day, Year)
M3-		30. Name and add	ress of person	who completed cause of	death (Iten	n 23a) (Type.	D41	+ 1 KI		2.050	, ~ ~ .
		JOGINDE	<u> </u>	MEHTA. MD.	769		ER DRI	VE TOWS	ON. ME	RYLAND 2	1204
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			For State Registrar	State of	Marylan	id / Depa <i>Cei</i>	artment of H rtificate of L	ealth and Death	d Mental Hy	/giene 2 (008	24748
	Db	9	1. Decedent's Name (First, Middle,	Last)					2. Date of D Month	eath Day	Year	3. Time of Death
*	Physici /Medi		Mar	y Baker	Smith				July	16, 2		10:00 a ^M
	Examir	ner	4a. Facility Name (If not institution, g				4b. City, Town, or		eath	4c. County		
			1323 Principio 5. Social Security Number 6		7. Age (In yrs.	last hirthday)	lf Under 1 Year	yville	frs. 8 Date of B	irth	Ceci	lace (State or Foreign
	Funeral Director		405-10-6860	1 M 2 K F	92	Yrs.	Months Days		lin. (Month, D	ay, Year) 5, 1916	Coun	entucky
			Usual Residence of Decedent									
	arylan show d at	-	10a. State 10b. County		10c. Cit	ty, Town or Lo					11	0d. Inside City Limits 1 ☐ Yes 2 No
	he Ma 8a-f	ecto		cil				yville	-	10g. Citizen of	Mhat Cour	
	with ta or 2	Funeral Director	10e. Street and Number 1323 Principio	Furnace E	Poad.		10f. Zip Code	1903	10	Tog. Citizen of	U.S.A	•
	reath ns 23 musi	era	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Decedent of H If Yes, specify Cuba		(Specify Yes or N	o- 14. Rad	ce - Americ	an Indian,
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. In a control of the wind than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	b	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed For 1 □ Yes If Yes, Give Year or Da	2 /€] •No e		lf Yes, specify Cuba 1 □ Yes 24ටktNo	in, Mexican, Pu Specify:	uerto Rican, etc.)	Bla Specif	ck, White, o	
5-0	72 ho natur dical I	eted	15. Decedent's	Education grade completed)		16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of t	workina	16b. Kind of B	usiness/Inc	dustry
121	within ene.	Completed	Elementary/Secondary (0-12) Twelve Years	College (1-	-4or 5+)	life. I	DO NOT use retired Homemake		U	Perso	nnal I	Residence
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Maryland	shou and M s mar		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Number or	Rural Route Num	ber, City or Town	, State, Zip	Code)
	and and m 27 m 27 her tra			daughter)		- F	Principi					
ore	ages 1 and 2 should b nt of Health and Ment t: If item 27 Is marked / or other traumatic e		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3		state	-	nsition (Name of matory or other place	i	Date	20c. Location	•	·
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie		R.A	. 20	S & Co., Inc	ss of Facility	7/18/08	1		Pennsylvania
Ba	perm Depa Impo any i		Monaso	n. tales	90M	$\mathcal{O}_{\mathcal{O}}$	Lee A. Pa Perryvill	tterson e, Mary	land 21	903-0766		<u> </u>
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that ca lly one cause on ea	aused the deal	th. Do not ent	er the mode of dyin	g, such as car	diac or respiratory	arrest,	114	Approximate Interval Between Onset and Death
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8760,	cate be executed physician and the burial-transit	a E	roodiang in docar, East	Due to (d	or as a consec	quence of):						
687	ficate physics	edical		d								
Box	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come pf pregn		7c-ti			23d. Da	ate of delive	ery
	e death	sicia	in the past 12 pronths? 1 □ Yes 2 □ No		ant at time of		∃Ectopic pregnancy ∃ Other (specify)			М	onth	Day Year
P.0	that the de ed by the detached	Phy	9 ☐ Unknown Part II. Other significant condition			culting in the u	nderlying sauce siv	an in Part I	23a Did	tobacco use con	stribute to ti	ne cause of death?
ds,	signe d be c	d by	Tarin outer organization	o continuating to do	an bat not roc	diang in the d	ndonymg badbo giv	on an eact.		Yes 2 No	3 ☐ Prob	
Records,	w require been sig should k	Completed							24a. Wa	s an 24h	Were auto	psy findings available
Re	The lay	m C							— aut per	opsy formed?	prior to cor death?	mpletion of cause of
Vital		Be C	25. Was case referred to medical					26. Place of I	1□ Yes Death (Check only		1 ∐ Yes	ZINO
or V	Physician: r this certific ral director,	To E	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆 Ir	npatient 2] ER/Outpatier	nt 3□ DOA Oth	er: 4□ Nursin	g Home 5 Re	sidence 6 □Ot	her (Specif	y)
o u	ding P. n. After t funera		27. Manner of Death ↑ Natural 5 Pending		of Injury h, <i>Day Year)</i>	28b. Time o Injury	Wor		28d. Describe	how injury occu	rred	
Division	Attending r death. ector; After by the funer	icati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	be 200 Place	of injury - At h	ome, farm, str	M 1 □	Yes 2 □ No	28f Location	(Street and Num	her or Rura	Il Route Number
Div	after after I Direct d in by	Certification:	4 Homicide determin		ng, etc. (Speci		,,,			own, State)	DOT OF TRAIN	
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the						h occurred at the tir					
	the H in 24 the Fi	Medical	one)	and mann		allori and/or ii						
	wit 7 Con	2	29b. Signature and title of certifier				29c. Licens	e number	11110	29d. Date signs	ed (Month,	Day, Year)
			Olomo os de dise	2	a of death //	m 20c) (T:=	40 0	1006	0447	4	116,	JUJ
	RF6	(Hame and address of person w	to completed cause	MN liter	(Type,	HIZL ST	.54	to 302	EKL	~ M	D21921
		ate	31. Date filed (Month, Day, Year)	32. R	istrar's Sign	ature	1.1.			11 0	- 7 4 41	
	Regist	rar	JUL 1 8	2008	Cen	D. A	The same					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 4:30 AM M Harold S. Twilley July 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Nursing Home Wicomico Salisbury 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Year) Months Director 218-24-5083 Sept. 22, 1930 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Directo MD Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 900 Booth Street 21802 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after toppartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ∐ Yes 2**XX**No Specify. Completed by 3 XWidowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 salesman insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanford F. Twilley Edna Graham ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32805 Willomet Court Parsonsburg, MD David B. Twilley (Son) 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stephens Cemetery 7-18-2008 Delmar, Delaware 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Short Funeral Home 13 E. Grove Street Delmar, DE ofications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the shock, or heart f Immediate Cause (Final Physician INTUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed Exami Due to (or as a consequence of): Box 68760 Physician/Medical the as attending | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t Hospital or Attending 5 Pending investigation 1 Matural n 24 hours after death.

Per Funeral Director: Af the full by the 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗜 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar

DHMH 17 Rev 1/2001

30. Name and address of r

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tres Spe Dr, SAlistary MD 2/804

erson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Yea **Physician** Maxzeller Leonard Thomas , Jr. Month 6:54 P ... /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death Fort FORT Washing ton Washing Hospital 6 eoges 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 578 42 1640 Washington DC 75 Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Items 23s or 28s-f ehow 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes X No Director Fort Washington MD P.G 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 511 Moat Way United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. African 1 Never Married 2 Married 1XXYes 2□No Korean IYes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lt. Col US Air Force Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maxzeller Thomas Sr. Selma Dorsey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Moat Wav. Fort Washington, MD 20744 19a. Informant's Name/Relationship (Type, Print) Bertha R. Thomas (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct 8,2008 20a. Method of Disposition

ABurial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Page Department o Important: If eny injury or Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Edheral Service Moenses Alexandria Ferry Road, Clinton, MD 20735 233. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arterioscherot Immediate Cause (Final Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ettending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Striknown peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has tirector, page 2 s 2 No 1 ☐ Yes 21 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1₽Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2-ER/Outpatient 3 □ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of persog who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day Year) 32. Raistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Légible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 July 13, 8:05 Marilyn Taleghani 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Charles LaP1ata Gensis Nursing Home 8. Date of Birth Pay, Feb 26, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Year) 39 Days 1 □ M 2 1 2 1 Months Winthrop, Mass 014 30 6599 69 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes X2X No Maryland Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20601 United States 2515 Lisa Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ TNO Specify: White 3 Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard T. Kelly Gertrude Christopher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2515 Lisa Drive, Waldorf, MD Marilyn S. Taleghani (Niece) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery July 18, 2008 Revere, Mass 4 ☐ Denation 5 ☐ Other (Specify 22. Name and Address of Facility ee Funeral Home, Inc 6633 01d 21. Signatury of Funeral Se Alexandria Ferry Road, Clinton, MD Do not enter the mode of dying, such as cardiac or respiratory arrest, plications that caused the deal 23a. Part 1. Enter the disea shock, or heart failure Immediate ause (Fi disease o ondition resulting in death) Due to (or as a consequent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to for sela consequence off Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatte event, the Medical Experient must be notified at

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical Be Completed by Certification: To

Division of Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the	ne underlying cause given in Part I.		co use contribute to the cause of death? 2 \[\text{No} \] No \[3 \[\text{Probably} \] Probably \[\frac{4}{2} \] Unknown
			24a. Was an autopsy performed	
25. Was case referred to medical	26. Place of Death (Check only one)			
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA Other: 4 Nursing	Home 5 Residence	e 6 ☐Other (Specify)
27. Manner of D ath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Tin		28d. Describe how in	njury occurred
3 Suicide 6 Could not be 4 Homicide determined			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	niner: On the best of my knowledge, niner: On the basis of examination and and manner stated.			
29b. Signature and title of certifier	4,0	29c License number	29d.	Date signed (Month, Day, Year)

State

Medical

30. Name and address of pe

31. Date filed (Month, Day,

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month **Physician** 0210 M Alan Lee Travis 08 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner Peninsula Regional Medical Center Wicomico Salisbury Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 218-80-2830 Director 44 02-13-1964 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 XYes 2 □ No **Funeral Director** MD Somerset Princess Anne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12013 Sherree Lane USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Somerset County Elementary/Secondary (0-12) College (1-4or 5+) 10 water & sewer operator Sanitary District none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marion Travis Linda Walston ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12013 Sherree Lane, Princess Anne, MD 21853 Robin L. Travis/Wife 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 07/19/2008 Beechwood Cemetery Princess Anne, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hinman Funeral Home Signature of Funeral Service bicensee 29a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart feature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VENTRILYLAR ASYSTOLK disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** OAVS INFAACTION MYOCARDINL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit ASUVD Due to (or as a consequence of): P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year Month Day □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 14 YPER FENSION 1 Yes HYPE BLIPEDEMIA 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 020912 07-14-08. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBUM MB 100 E. Shure Chodwick. 10 State

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Ju1y Joan Marie Tennyson 17, 2008 4:50 pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Mary's Nursing Center Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🗓 F Months Days Hours Yrs. Director 212-54-2247 67 10/14/1940 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprision must be multified at once. Director 1 ☐ Yes 2 No Maryland St. Mary's Scotland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 15258 Tennyson Lane 20687 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [Z]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☒ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🖔 No Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Postal Clerk U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Michael Balta Eleanor Bradburn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George P. Tennyson/Husband 15258 Tennyson Lane, Scotland, MD 20687 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 07/21/2008 Ridge, Maryland Michael's Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ch as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) ninuls /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a con Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 | Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□No 1 ☐ Yes 2 ♣ No 1 Tyes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation I Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier 1 🗟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one)

State Registrar 29b. Signature and title of certifier

James P.

31. Date filed (Month, Day,

of person who complete

Jarboe,

Year)

JUL 2 1 2008

DHMH 17 Rev 1/2001

and manner stated

cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

24035 Three Notch Road, Hollywood, Maryland

29d. Date signed (Month, Day, Year)

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Director

"natural", or items 23a or 28a-f shovidical Examiner must be notified at Pages 1 and 2 should be filed within 72 hours after death vent of Heatth and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23s event, the Medical item 27 is marke other traumatic = 6 permit. Page Department of Important: If any injury or

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

physician and s the burial-tran attending p 38 been signed by the should be detached director. this After the Funeral Director: Af within 2.

To the Hospital or Attending Physiclan; The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Month Day Year Ann 25, 2008 7:20 A. July Betty Taylor 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Hagerstown Washington 11 W. Baltimore St. Apt. 8. Date of Birth (Month, Day, Year) Feb. 16, 1945 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 1□M 2□F 63 Maryland 220-40-1194 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County Hagerstown Mđ. Washington Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21740 U.S.A 11 W. Baltimore St. Apt. 108 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker *Home* 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James R. Whitford Jr. Betty Louise Koelker ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1052 C Noland Dr. Hagerstown,Md. 21740 Renee A. Young (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Julu 26, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Smithsburg,Md. 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 12525 Bradbury Ave. Jeffrey kec MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final moen disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Kes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: EXW0 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) (Month, Day, Y

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 12:45 PM TAVENNER 2008 JOSEPHINE ANNE 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomeri Montgomery Hospital Olnu General If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Min. Year) 1 ☐ M 2 🛣 F 1922 New Jersey 85 Dec. 1 577-26-7651 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Olney 1 ☐ Yes 2 No Md. Montgomery 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 20832 United States 3501 Tavenner Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Restaurant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Florence O'Brien Thomas O'Brien, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3604 Patrick Henry Drive, Olney, Md. Thomas Tavenner / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State 7/17/08 Silver Spring, Md. Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee. murie 20882 P. O. Box 5038, Laytonsville, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Incarcerated Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 **X**No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ◯ No autopsy 1 □Yes 2 No 26. Place of Death (Check only one)

Physician /Medical **Examiner**

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Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

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Director

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at

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permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, The ORGS.

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Baltimore, Maryland 21215-0036

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29a. Certifier

and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Bichhuen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1810 1/inh

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31. Date filed (Month Day, Year)

32. Registrar's Signature 1 5 2008 JUL

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		Division of Vital Records, P.O. Box 68760,
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/Medic Examin		Angelo Joseph 4a. Facility Name (If not institut			ber)		4b. City, To	own, or	Location of	of Death	July :	10,	4c. County	of Death	2.43	A
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and 2 saith a 27 is er trai		Theresa Trois	i/ Wife	:		1230	9 Tilbu	ury	Lane	Bow	ie, MD	20	715			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Exandrate must be notified at once.		20a. Method of Disposition 1	n 3⊡Remo	val from St	20b. J	Place of Dispo	sition (Name natory or othe	of er plac	e)	D	ate	200	. Location -	City or To	wn, State	
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permit. Departr Importa any Inju		21. Signature of Funeral Service	ricensee				2. Name and A								1 Home	:
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)	ying Physicia ai Examiner: (a	n: To the b On the bas and manne	sis of examina	owledge, deat ation and/or in	h occurred at vestigation, ir	t the tin	ne, date ar pinion, dea	nd place, ith occurr	and due to th ed at the time	e caus e, date	se(s) and ma and place,	anner as s and due to	tated. the cause(s)	
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62	·	30. Name and address of person	who comple		of death (Iter	m 23a) (Type,	Print)	0	efe	nso	Hn	~	Cro	ftizz	n	2 72111
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Registra		JUL 1	6 2008	the.	we,	K A	ale									

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760, To the Hospital or Attend within 24 hours after death To the Funeral Director:

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAMES

address of person who completed a

Side

Jul 1 5 2008

DHMH 17 Rev 1/2001

29c. License number

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29d. Date signed (Month, Day, Yang July

Christian Jensen Mb Deputy

POB #690, DENTON MD 21629

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Ma			rtment of He rtificate of D			Reg. No.	100	24/50
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	Examin	er	4a. Facility Name (If not institution, given Montgomery Gener				4b. City, Town, or L	01ney		4c. Court	Montgo	omerv
*	Funeral		Social Security Number 6. 8	Sex 7. Age	e (In yrs. last birt	hday)		If Under 24 Hrs.	8. Date of Birth (Month, Day) (Vear)		lace (State or Foreign
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Maryland 21215-0036	s 1 and 2 should be filed within 72 ho if Health and Mental Hygiene. Item 27 is marked other than "naturither traumatic event, the Modelal	일	Nathan	Vagins					Leah Go	1dman		
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Baltimore,	Pages nent of hint; If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐				sition (Name of natory or other place)	i -		20c. Location		
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			30. Name and address of person who	GOM F	9901 N		Print) cal Center D	rive, Rock	ville, Ma	ryland 2	20850	
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			State Registrar	<i>C</i>	ertificate of L		Reg. No	2008	24759
	Physicia	an	Decedent's Name (First, Middle, Last)			2.	Date of Death Month Da		3. Time of Death
	/Medic		Reba Collison W 4a. Facility Name (If not institution, give street and number)	heatley		Location of Death	uly 18	2008 c. County of Deat	10:35 P ^M
	Examin	er				alsburg	40	Caroli	
. •	Funeral		7760 Federalsburg Highwa 5. Social Security Number 6. Sex 7. Age	a y (In yrs. last birthda	ay) If Under 1 Year	If Under 24 Hrs. 8.	Date of Birth	9. Birt	hplace (State or Foreign
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	ms 2:	Funeral	11 Marital Status 12. Was Decedent Ev		13. Was Decedent of H If Yes, specify Cuba			14. Race - Ame	rican Indian,
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at ent, the Medical Examiner.	Completed	15. Decedent's Education (Specify only highest grade completed)	1 (G	ecedent's Usual Occup live kind of work done o le. DO NOT use retired	durina most of workina	16b. I	Kind of Business/	Industry
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<u>a</u>	lid be fental rked tlc ev	To B	Clarence Washington	Adams		01evia	Adams		
Maryland	I 2 should be filed within 72 hours after death with the Marylan in and Mental Hygiene. I is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show is marked other than Medical Examiner must be notified at transmatic event, the Medical Examiner must be notified at	Г	19a. Informant's Name/Relationship (Type. Print)	19b. M	ailing Address (Street	and Number or Rural F	Route Number, City	or Town, State, 2	Zip Code)
Σ.	and 2 ealth n 27 i		Wayne A. Wheatley So					-	and 21601
ore	ges 1 t of H If iter or oth		20a. Method of Disposition 12☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, o	sposition (Name of crematory or other plac			Location - City or	
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Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e		21. Signature of Fluneral Service/Licensee		22. Name and Addre	ss of Facility neral Hom	e, P.A.	ъ.	21629
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ie.	Dhusisian		shock, or heart failure. List only one cause on each line	Э.	1		, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
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	oe executed cian and ourial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	consequence of):			- · · · · · · · · · · · · · · · · · · ·		
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687	law requires that the death certrificate be as been signed by the attending physicia 2 should be detached for use as the bu	Physician/Medical	d						
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ō	Physer this eral di		27. Mannel of Death 28a. Date of Injury	y 28b. Tim	ne of 28c. Injur	4 □ Nursing Home	d. Describe how in	6 ☐Other (Spe jury occurred	ecity)
lon	Attending r death. ector: Afte by the fune	tior	Natural 5 ☐ Pending (Month, Day) 2 ☐ Accident investigation	Year) Inju		k? Yes 2 □No			
Division	ar dez	Certification:	3 Suicide 6 Could not be determined 28e. Place of injur		, street, factory, office	28	f. Location (Street and City or Town, Sta	and Number or R	ural Route Number,
ō	ital or irs aftural Di ral Di								
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) (Check one) (Che	examination and/o					
	thin 2 the outple	Med	one) and manner stat 29b. Signature and title of certifier	ed.	29c. Licens	se number	29d. [Date signed (Mon	th, Day, Year)
	F ≥ F 8					53815		_ / . /	800
		_	30. Name and address of person who completed cause of de	eath (Item 23a) (Tu				12/a	V - 0
		_	Korah Pulimood, M.D.,			et, Dent	on, Mary	yland	21629
	Sta		31. Date filed (Month, Day, Year) 32. Registral	r's Signature					
	Regist	rar	AAL W. 1 E000	and do	Comment of the second				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month UI 2008 Jolley Wangus /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and humber) 4c. County of Death **Examiner** brchester General Hospital conchester ambrida 5. Social Security Number er 1 10. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Hours 1 ☐ M 2 🗷 F 216-18-8945 86 Yrs. Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglane. Important: if item 27 is marked other then "netural", or iteme 23a or 28a-f ehov any injury or other traumatic event, the Medical Examiner must be notified at once. ambridge You zip Code 1 Yes 2 No Director Maryland 10e. Street and Number 10g. Citizen of What Country? reek Road 21613 J.S.A 2369 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No 3. Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Processor anner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Tharles George Jolle

19a. Informant's Name/Relationship (Type, Print) Rosie Ward ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) T 423 Compar St Cambridge MD 21613

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City of Comparison or Other place) aurine Ennals/Daughter 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State hrist Rock Cemeter 107-21-08 Cambridge, maryland 812 Hubbard St. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Boardley Funeral Home Cambridge, MD21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician heumoni week /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consecución of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) ettending physician for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 4 Pregnant at time of death Month Day Year 5 Other (specify) ed by tha e 9 Unknown signed by contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DIAbetes 2) ENO 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 500 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Anatural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation after deeth.

Director: Af
d in by the fu 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29b. Signature and little of certifie 29d. Date/signed (Month, Day, Year) 0

Registrar DHMH 17 Rev 1/2001

State

ar's Signature

hride

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 1 8 2008 J

A. NARR

2015 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Edna Mae Warren 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 638 Drin He HAMPTON DXON Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🙀 F Months Days Min. 578 52 3634 68 Director Dec 14, 1939 Alabama Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

The marked other than "natural", or items 23a or 28a-f show other traumatic event, its Maryland Earth of the control of the cont 10b. County 10a. State 10c. City. Town or Location 10d Inside City Limits MD Director Prince George's 1 ☐ Yes 2 √2 No Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 638 Hampton Drive 20745 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2√√No Be Completed by Specify Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alphonso Harris Melissa Tucker ပ (Daughten) b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shirlitta Warren-Cropper 1258 Anacostia Road S.E., Washington, DC 20019 Pages 1 gment of Hr 20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any injury or o 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery July 17, 2008 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Euneral Service Licens Alexandria Ferry Road, Clinton, MD 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only be cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 □Yes 2 No 25 Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) 1☐ Tes 2☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records,

reral Director: A within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 31. Date filed (Month, Day, Year) gistrar's Signature State Registrar **ORIGINAL**

Amended item #26 per Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. physician 07/29/08 cs State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 07 **Physician** 20 ð8 1246 Darlene Wengerd Bernice /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS Braddock Campus Cumberland **Allegany** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🕱 F Sept. 28,1931 Pennsylvania Director 200-24-4908 76 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or be ns 23a o 21536 USA 3287 Hare Hollow Rd. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must gonee. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify. þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Buterbaugh Myrtle Lindeman ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3287 Hare Hollow Rd., Grantsville, MD 21536 Joseph E. Wengerd/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Country Side Crematory July 21, 2008 Davidsville, PA 4 Donation 5 □ Other (Specify) 21. Signature of Fungal Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner estive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine Dokem Due to (or as a consequence of): physician ar Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) by the a tached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown umothoras 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1□ Yes 20 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2[XNo Hospital: Other: 4 Nursing Home 51 Presidence 6 Other (Specify) 2 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3X DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation After Medical Certification: 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: completely filled in by the f

and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 21, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 124 Miller St., Grantsville, MD Robin Bissell, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2 3 2008

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** iam MALLONI /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Doryland nisther 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** 10M 20F Months Min. Days Hours Director Marylanc Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Otiqo Director MC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ō 2074 Uniter Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural" Completed Department of Health and Mental Hygiene Important; If item 27 is marked other than "natur any injury or other traumatic event, the Medical once, 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AU AU 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stragt Heights Md 26743 SUYQ (CQ \ 3 □Removar from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 4 Donation 5 Other (Specify) 5 0 10 10 10 07 29 20081 Clinton buthern Maryland permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee H74 Director 1000 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) - Pre viable Physician Extreme /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 2008 07 9 Unknown 25 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0063068

Registrar

State

7503

SURRATTS RD CLINTON MD 20735

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jean-

31. Date filed (Month, Day, Year)

hilippe

32. Segistrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division of Vital Records, P.O. Box 68760.

			1 - State Registrar					Cer	tificat	e of l	Death	•		Reg. N	10.21	108	24	191
	Physicia	an	1. Decedent's Name										2. Date of De Month		ay ,	Year	3. Time of	Death
	/Medic		Caro1	Ann	Wiles								07	/	14	08	0/05	- м
Markey .	Examin	er	4a. Facility Name (If Peninsul				Center	r		Town, or lisb	Location	of Death		4		y of Death		
	Funeral		Social Security Nu		6. Sex		(In yrs. last bii		If Under	r 1 Year	If Under		8. Date of Bir (Month, Da	rth		9. Birth	place (State or	r Foreign
	Director		213-98-56	89	1□M 2 F	1	38	Yrs.	Months	Days	Hours	Min.	July 2			Mary	ntry) 71and	
7	2 _		Usual Residence of I							,								
0	show	<u>_</u>	10a. State	10b. County			10c. City, Tow	n or Loc	ation							1	I0d. Inside Cit 1 ☐ Yes	
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4	a or	늅	10e. Street and Num			1			10f. Zip		1050			10g. C		What Cour	ntry?	
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, 4	riten	듄	1 Never Marrie	ed 2 Marrie	Armed 1 ☐ Yes	Forces?				5.4			ecify Yes or No Rican, etc.)			ick, White,		
	Evan	þ	3 ☐ Widowed 4		If Yes, t	aive Dates:		1	□Yes	2 2000	Specify	' :			Specif	^{fy:} Whi	lte	
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	perim. Fages I and Should be filed within 7.2 hours are regain with the maryinan perime. Fages I and Should before the filed of the file and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantime must be notified at once.		1/2 Burial 2 ∟ 4 Donation 5	JCremation 5 □Other <i>(Sp</i>	3 □ Removal from ecify)	n State	Allen	•	-		1	07/17	7/2008	Α1	len,	Mary	land	
	apartr ports ny inju		2). Signature of Fun	eral Service L	icensee			H11	Name ar	nd Addres	ss of Facili	ity Home						
נ נ	10 E 20 E	9	AMOS	Llekn		- MOC		111	673 9	Somer	set	Ave.,	Princ		Ann	e, MD	21853	
		/	23a. Part 1. Enter the shock, or heart	e disease, or o t failure. List o	complications that only one wuse or	caused the	ne death. Do	not ente	er the mod	de of dyin	ng, such as	s cardiac c	r respiratory a	ırrest,			Approximate Interval Betw Onset and D	ween
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9	the a	Physician	1 □ Yes 2 🔯 9 □ Unknown		4 □ Pre 9 □ Un		ime of death	5 🗆	Other (s	pecify)						oriar .	Duj .	ou,
- ted	ned by the		Part II. Other signific	cant condition	ns contributing to	death but	not resulting i	n the un	derlvina d	ause give	en in Part	I.	23e. Did 1	tobacco	use con	tribute to t	he cause of de	eath?
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_ ي ا	certificate ha		25. Was case referre	ed to medical							26 Plac	e of Death	1 ☐ Yes	2 📑	10	1 ☐ Yes	2 No	
Attending Physician: The law requires that the death	is cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ €		Hospital: 1	Inpatient	2 ER/O	utpatient	3 D	OA Othe	or:		ne 5∐ Resi		6 ∏Otl	her (Speci	fv)	
. i	h. After this of	L	27. Manner of Death 1 ☑ Natural	5 Pending		e of Injury	28b.	Time of Injury	2	28c. Injur Work			28d. Describe				,,	
	or: Af) ăți	2 Accident	investiga	ation	,,,		, ,	М		Yes 2]No						
TA T	irect n by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ned 28e. Pla	ce of Injury ding, etc.	/ · At home, fa (Specify)	arm, stre	et, factor	y, office		2	28f. Location (City or To	Street a	and Numi	ber or Rura	al Route Numb	ber,
) [within 24 bours after death. To the Funeral Director: After completely filled in by the fun		200 Comition	17	Dhuai i -					1 -4					(-) ·			
HOS	Fune Fune	Medical	29a. Certifier (Check only one)	2 ☐ Medical E	Physician: To t xaminer: On the	basis of e nner state	examination ar	e, death nd/or inv	occurred estigation	n, in my o	ne, date a pinion, de	ath occurr	and due to the ed at the time,	date a	(s) and m nd place,	anner as s , and due t	stated. o the cause(s))
othe	omple	Med	29b. Signature and ti	itle of certifier					290	c. Licens	e number			29d. D	ate signe	ed (Month,	Day, Year)	
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7		}	30. Name and addre		ho completed ca	use of dea	ath (Item 23a) Short s Signature	(Type, F	Print)	er 5	-1_1	, -		'	J	,		
2	Eb			Chodnic	Ki 4	100 2	. shor	e	DIVE	<u> </u>	squis	bury	Mo					
	Stat	te	31. Date filed (Month		7 2000 32.	Re "strar"	s Signature											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Gerard Joseph White 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day July 23, 2008 0645 hrs Medical Examiner Gerald Joseph White c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Glen Burnie 454 Old Quaterfield Road If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) Days Months Director December27 943 64 Louisiana XM 437-60-2652 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location X Yes 2 No 28a-f show s 23a or 28a-f show e notified at once. Sacramento Califorhia Sacramento Director 10g. Citizen of What Country 10f. Zip Code 10e, Street and Number the N 3816 Natoma Way 95838 U.S Α 14 Race - American Indian Black. with 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-Funeral Was Decedent Ever in U.S. 11. Marital Status ě White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? death 1 Never Married 2 Married must 2 1 X Yes f Yes, Give Year No 10 Specify: Black Yes 2X No specify: Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. 4 X Divorced 1982 Widowed marked other than "natural", event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Post Office 21215-0036 Mail Carrier 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daisy Mae Brown mportant: If item 27 is marked njury or other traumatic event, James Walter White.Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Yolander Dorsey/Daughter 3816 Natoma Way, Sacramento, California 9583 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition Baltimore, crematory or other place) X Burial 2 Cremation Removal from State Sacramento, California Camellia Memorial 7-31-08 ment Other Specify: Donation 5 22. Name and Address of Facility 21. Signature of Funeral Seg ice Licensee Marzullo Funeral Chapel, P. A. Road Baltimore, Maryland 21214 23a. Part I. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on 'Medical a. Hypertensive Atherosclerotic Cardiovascular Disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and #1 as noted per ME G882 8/16/08 TT Physician/Medical XAMENDED r use as the burial -LINPENDED To the Hospital or Attending Physician: The law requires that the death certificate be entitin 24 hours after death. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Part II. Other significant conditions Yes 2 No 3 Probably 4 V Unknown ş Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 1 V Yes certificate 26.Place of Death (Check only one 25. Was case referred to medical Be Other₄ examiner? Residence 6 V Other: Scene DOA Nursing Home 5 ER/Outpatient 3 Inpatient this 2 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year 28b. Time of Injury Авег 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending Director: d in by the f 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) filled in (Specify) Fo the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 23, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

OCME

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Phys / /Me Exa

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760,

		For State Registrar	State	Ji Mai yiai	•	rtificate of	Death	_	Reg. No.	2008	24	766
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min	er	4a. Facility Name (If not institute FREDERICK	MEMORIAL H			FREDER	r Location of Death			REDERIC		
ral tor		5. Social Security Number 173 24 4634	6. Sex 1 □ M 2 🗶 F	7. Age (In yrs. 77	last birthday Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da OCT. 5,	th ay, <i>Year)</i> 1930	Cor	nplace (State of untry) nsylvar	
		Usual Residence of Decedent 10a. State 10b. Cou		10c Cit	ty, Town or L	ocation					10d. Inside Cit	ity Limits
70	JO.		ederick	1	Freder						1 X Yes	•
	irect	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Cou	untry?	
	Funeral Director	750 Carro	ll Parkway-	apt. 3	- B	21701			Uni	ted Sta	tes	
	ıner	11. Marital Status		cedent Ever in U		Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No)-	14. Race - Amer Black, White		
	þ	1 ☐ Never Married 2 ☐ I 3 🗶 Widowed 4 ☐ Divor	Married 1 ☐ Yes	2 ∏ No Sive		1 □ Yes 2 No					hite	
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	Be Co	17. Father's Name (First, Mid					18. Mother's Nam	e (First, Middle,		•		
	To B	Edward	Walter	r.	Ryan		Doroth	у Е.	Brad	field		
	_	19a. Informant's Name/Relati	onship (Type. Print)	hter			and Number or Ru Lane / El			r Town, State, Z	lip Code)	
		20a. Method of Disposition	, 200			osition (Name of ematory or other pla		Date		cation - City or T	Town, State	
any mjory or other naumanc event, presentent evaluate must be inclined at <u>once.</u>		1 ☐ Burial 2 🖫 Cremati 4 ☐ Donation 5 ☐ Othe	r (Specify)	n State	auffer	Cremator	y 07/15			erick,		nd
ouce.		21. Signature of Funeral Serv	n Ce Licensale	10000	/ /		ess of Facility Sta numtown Pi					
ian		23a. Part1. Enter the disease shock, of heart failure. Immediate Cause (Final	e, or complications that List only one cause on	caused the deat each line.	th. Do not er	nter the mode of dyi	ng, such as cardiac	or respiratory a		CK, FID	Approximate Interval Bette Onset and I	ween
cal		disease or condition resulting in death)	a	o (or as a conseq	juence of):	ac 1	remor					
er		Cognosticily list conditions	b/	Penic	ard	ial	effu	tion				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		o (or as a conseq	juence of):		00					
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	a E	recoming in deality East	Due to	o (or as a conseq	juence oi).							
	Medical		d									
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregnate birth 2 Feta gnant at time of a	al death 3	□ Ectopic pregnand □ Other (specify) _	су		2	23d. Date of deli Month		Year
		Part II. Other significant con	ditions contributing to	death but not res	ulting in the	underlying cause gi	en in Part I.	23e. Did t	tobacco u	se contribute to	the cause of d	leath?
	d by							1 🗆 '	Yes 2	□ No 3□ Pro	obably 4	Unknown
	Completed							24a. Was			topsy findings	
	mo							autoj perfo 1 □ Yes	psy ormed? 2. □Mo	death?	completion of c	ause or
	BeC	25. Was case referred to med examiner?	lical	/			26. Place of Dear			1 12100		
		1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatie	ent 3 DOA Oth	ner: 4 Nursing H	ome 5 🗆 Resi	idence 6	6 □Other (Spec	cify)	
	ation:	Z L Moordon	nding (Mo estigation	e of Injury onth, Day, Year)	28b. Time Injury	Wo	ryat k?]Yes 2 □ No	28d. Describe	how injury	y occurred		
	Certification: To		uld not be termined 28e. Place buil	ce of Injury - At hiding, etc. (Special	ome, farm, si	reet, factory, office		28f. Location (City or To		d Number or Ru)	ıral Route Num	iber,
	Medical (ifying Physician: To thical Examiner: On the and ma									s)
	Σ	29b. Signature and title of cer	World	MD	-	29c. Licen:				e signed (Month		
		30. Name and address of per					rederick	, Maryla	and	21701		
Sta	te	31. Date filed (Month, Day, Y	ear) 32.	Begistrar's Signa	ature			- J				
gistra	- 1	JUL	5 2008	aur.	B. A	medi						

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 24767 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 6 2008 Geneva Catherine Werner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Manov lanokin Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗡 F Months Days Hours Min Yrs. Director 05-05-1917 Maryland 212-30-9201 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir items 23a or 28a-f show their must be notified at 1 XYes 2 No Directo MD Somerset Princess Anne 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11974 Edgehill Terrace or items 23a 21853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify 2 or other traumatic event, the Mudical Exer 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lloyd T. Widdowson Christena Metz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health at Important: If Item 27 is any injury or other trau <u>once</u>. 3189 River Valley Chase, West Friendship, Mo 21794
Date Date 20c Location City of Town, State Wallace E. Boston, Jr./nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State St. Andrews Episcopal 07/20/2008 Princess Anne, MD 1 □ Donation 5 □ Other (Specify) signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home 27a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21853 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIOMYOPATITY 5 4 cers /Medical Due to (or as a consequence of) Examiner Sycar Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine use as the burial-transit resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE 23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death [Check only one] Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) DR. USHA DO57359 NATESAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

July 16,3008

Somerset Cseneva W. Werner

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

SALISBURY

istrar's Signatur

DIVISION SI

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31. Date filed (Monti

Physician

/Medical

Examiner

Funeral

ural", or items 23a or 28a-f show Examiner must be notified at

Director

Funeral

urs af al", or Exam	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Y	es 2 No	Specify:		_ '	Specify: V	White	
72 ho natur ilcal I	eted	15. Decedent's E (Specify only highest g	Education rade completed)	16a. Decedent's	Usual Occup	oation during most of wo	rkina ı	16b. Kin	d of Business/	ndustry	
within iene.	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ot use retire al Foi	during most of wo d) Ceman		Bet	hlehem	Steel	
e filed al Hyg other vent,	Se C	17. Father's Name (First, Middle, Las	st)				me (First, Middle,	Maiden S	Surname)		
wuld by Menta	ToE	Auty Wayne Balla	rd,Sr.			Mabel He	enderson				
and 2 sho saith and 1 27 is ma er trauma		19a. Informant's Name/Relationship Mrs. Jean Louise	(44770)	1		and Number or R a Paix La	ural Route Numbe ane Bal		Town, State, 2 ore, MD.		
permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or any injury or other traumatic event, the Medical Examono.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from State ☐ CO	lace of Disposition emetery, cremator US Funera	y or other pla	pel Aug.	Date . 03,		eation - City or est Hil	Town, State 1 , Maryland	
permit. Departn Importa any inju		21. Signature Funeral Service Lice	ensee J. Gav	72. Nai Peac 23.	ne and Addre Ceful 1 25 Yorl			eral8 un,Ma	Cremat aryland	ion Ctr.,P 21093	• Ē
Physician		23a. Pan . Enter he di ease, or of shoo, or he rt fa ure. List on Immediate Cause (Final		7						Approximate Interval Between Onset and Death	
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sician: The law certificate has t irector, page 2 s	Com						autop perfo	rmed? 2 ☐ No	death?	completion of cause of 2 No	
clan: ertific ector,	Be (25. Was case referred to medical examiner?					eath (Check only o	ne)			_
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ending l ath. or: After ne funer	ation:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	- I	28b. Time of Injury	28c. Inju Wo	ryat rk? ∣Yes 2 □ No	28d. Describe h	now injury	y occurred		
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To the Hospital or Attending Physician: within 24 hours after cleath. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical	29a. Certifier 1 Certifying F (Check only one) 1 Medical Ex	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, death occ tion and/or investi	urred at the t gation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
Vithi Vithi Con	Ž	29b. Signature and title of certifier	0 10		29c. Licens	se number		29d. Date	e signed (Mont	h, Day, Year)	
0		Milip//le	Swell, M	?D	D4	7221		Jul	y 31, 2	2008	
10		30. Name and address of person wh	· ·			· ·		-	01004		
()		Philip R. McDowel 31. Date filed (Month, Day, Year)	1 M.D., 6/U1 N.		St.,	Baltimor	e, Maryl	and	21204		
Sta Registr		AUG 0 1 200		Sperte							
HMH 17 Rev 1/2	001	v • mr 307		ORIGI	NAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

10f. Zip Code

TOWSON

If Under 1 Year | If Under 24 Hrs. Months Days Hours Min.

2. Date of Death Month

2008

1800

10d. Inside City Limits

JULY 30,

4c. County of Death

4b. City, Town, or Location of Death

BALTIMORE 8. Date of Birth (Month, Day, Year) Aug. 29, 1929

 Birthplace (State or Foreign Country) Moreland, OK.

White

78

7. Age (In yrs. last birthday)

10c. City, Town or Location Baltimore

1 ∐ Yes 2∛∑ No 10g. Citizen of What Country?

Maryland Baltimore County 10e. Street and Number 108 La Paix Lane

11 M 2□ F

21204 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) United States 14. Race - American Indian, Black, White, etc.

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

215-22-3447

10a. State

Usual Residence of Decedent

AUTY WAYNE BALLARD

4a. Facility Name (If not institution, give street and number)

10b. County

GREATER BALTIMORE MEDICAL CENTER

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2½ No If Yes, Give Year or Dates:

1 ☐ Yes 2 ☐ No Specify:

	Exa	mine	
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

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Physicia	n	Registrar 1. Decedent's Name (Fig. 1)	rst, Middle, La	ast)			erillicate o	Deaur		2. Date of Death Month	n Day Ye	3. ar	Time of Death
/Medica Examine	al	4a. Facility Name (If not	D M 1	1 11	1 1 1	1 7	4b. City, Town	1		07	27 200 4c. County of D	0	- JCO M
Funeral Director		5. Social Security Numb	er 6.	Sex 1 M 2 KF	7. Age (In yrs.	_				8. Date of Birth (Month, Day,	Year) 9. 9-1931	Birthplace Country)	(State or Foreign
Maryland -f show led at		Usual Residence of Dec 10a. State 10b MD	cedent c. County	N/A		y, Town or							side City Limits
h with the	al Director	10e. Street and Number 2904 Roc		Avenue	9		10f. Zip Cod	le 212.	15	10	Og. Citizen of What	Country?	
al", o	by Funeral	11. Marital Status 1 □ Never Married 3 ☒ Widowed 4 □		12. Was Dece Armed Fo 1 Yes If Yes, Gi Year or D	No No	S. 1	3. Was Decedent of If Yes, specify C			cify Yes or No- Rican, etc.)	14. Race - A Black, V	merican In Vhite, etc. Black	
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ould be filed Mental Hyg arked other atic event, I	To Be C	17. Father's Name (Firs	t, Middle, Las ggs		N/ A			18. Moth	verta	a Simma	faiden Surname)		
1 and 2 sh Health and em 27 is m ther traum		Sheila S 20a. Method of Dispositi	imms-I		20b. F	536	53 King	Arth	ur C	ircle	Balto, 20c. Location - City	MD	21237
iit. Pages artment of ortant: If it ortany or o		1 Burial 2 Cr 4 Donation 5 2 21. Signature of Funera	emation 3 [] Other (<i>Spec</i>	ify)	State	emetery, c	nematory or other demoria. 22. Name and Ad	place)		-2008 I	Randalls		
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Physician /Medical Examiner		shock, or heart fail Immediate Cause (Fina disease or condition resulting in death)	llure. List only	y one cause on e	(or as a conseq	eil L	ng Carc			respiratory arre		Inte	val Between et and Death
be executed cian and curial-transit	cal Examiner	Sequentially list condition if any leading to immercause. Enter Underlyin Cause (Disease or injur that initiated events resulting in death) Last	ons, ti-te g y	c	or as a conseq								
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Physician: this certific ral director,	To Be	25. Was case referred to examiner? 1 ☐ Yes 2 No 27. Magner of Death	o medical	Hospital: 28a. Date	-	ER/Outpat	IEIIL 3 DOA	Other: 4 🗆 N	ursing Hom		nce 6 Other (5	Specify)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification properties of the foundation of the funeral director, it is a few parts of the funeral director.	Certification:	1 Natural 5 2 Accident	☐ Pending investigation ☐ Could not be determined	on 28e. Place	th, Day Year)	Injur		njury at Work? 1 ⊡ Yes 2 ⊡ ice]No		w injury occurred reet and Number of s, State)	r Rural Rou	ite Number,
e Hospital 24 hours a E Funeral letely filled	edical Ce	29a. Certifier (Check only one)	Certifying P Medical Exa	miner: On the b	e best of my kno easis of examina ner stated.	wledge, de tion and/or	ath occurred at th investigation, in n	e time, date a ny opinion, de	and place, a	and due to the ca	ause(s) and manne ate and place, and	er as stated due to the	cause(s)
To th withir	Me	29b. Signature and title	of certifier	E-M	D.		P	ense number 2221	7		O7/27	lonth, Day,	Year)
5		30. Name and address	ebror	M.A.	22 5	5.6 re	e, Print) ene St.	Baltin	rore, x	10 212	01		
Stat Registra		31. Date filed (Month, D		2008	egistrar's Signa	ture	Sail						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 6:00 A JMTy 31, □2008 Adeline Berluti 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Good Samaritan Nursing Home N/ABaltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Jan. 24, (In yrs. last birthday 9. Birthplace (State or Foreign New York 126-12-6895 1 M 200 Ĩ913 Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 □ No Baltimore MD N/A 10g. Citizen of What Country? 10f. Zip Code 21239 10e. Street and Number 1650 Woodbourne Ave. Apt. 103 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ₹₹No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2 Married _{Specify:} White 1 ☐ Yes ŽŽ No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marie Cinque Louis Berluti 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Parkville, MD 21234 3214 Chesley Ave. <u> Anita Balsamo / Sister</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4,2008 Timonium, MD 4□Donation 5₺Other(Specify)EntombmentDulaney Valley Mem. Aug. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Rd. Leonard J. Ruck, Inc. Baltimore, MD 21214

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

Funeral

Director

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at

use as the burial-transit been signed by the should be detached thin 24 hours after death.

the Funeral Director: After Puneral Director After Interest of the fur

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Do not enter the mode of dying, such	h as cardiac or respiratory arrest,	Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	a. Progressive Deeln	.e	Onset and Death
Toda Evalling	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Forling tu - Discar	
) order mine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date Mont	
	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in P	Part I. 23e. Did tobacco use contrib	1
			autopsy pri	ere autopsy findings available for to completion of cause of ath?
	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Handleli Out	Place of Death <i>(Check only one)</i> ☐Nursing Home 5☐ Residence 6☐Other	(Specify)
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes	28d. Describe how injury occurred	
3	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number City or Town, State)	r or Rural Route Number,
5		ysician: To the best of my knowledge, death occurred at the time, dat		

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifie

MD

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).
SHOALD A HAS HOMI MD 826 N. ENTAW ST SNITE 208 (3ALTIMONE MI) 2114

D31464

29d. Date signed (Month, Day, Year)

and manner stated

08-05447 James Nathania	l Bro		Print in Black Inc Maryland / Depar			•	_	bie.	
		I- For State Registrar		tificate of l			Reg.	No. 201	18 247
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)					2. Date of Death Month D	ay Year	3. Time of Death 1913 hrs
Wedical Exami	ilei	4a. Facility Name (if not institution, give s		WM 4b	. City, Town, or	Location of Death	July 15, 200	8 4c. County of De	
		506 North Paca Street Apt.			Baltimore		•	NA	
Funeral		Social Security Number 6. Sex-	7, Age (In yrs. la	st birthday)	If Under 1 Year		,	MM/DD/YYYY) 9.	Birthplace (State or reign (Country)
Director		W-5-10-10 12 +	2 F 65	Yrs.	Months Day	S Hours Will	Nev. 22	1942	Country) 1/and
any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	n				10d. Inside City Limits
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e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mertal Hygiene. 'item 27 is marked other than "natural", or items 23a or 28a-f show r traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number			10f. Zip Code		10g.	. Citizen of What C	ountry?
h the A 3a or		506 Paca	St.		212			u. 1	.A .
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ours af atural	d by	15. Decedent's Education (Specify only	Dates:	16a. Decedent's	Usual Occupa	ition (Give kind of		6b. Kind of Busine	ss/Industry
16 n 72 h n 72 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mos	_	e. DO NOT use ret		0111	1
5-0036 led within 7 Hygiene. other than	mo	17. Father's Name (First, Middle, Last)		196	/6	18. Mother's Name	e (First, Middle, Mai	iden Surname)	itomy
215 be filed ntal Hy rked of	BeC	James Brown	•			Grace	11/1/50	(
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after d nt of Health and Mental Hygiene. If filem 27 is marked other than "natural", or other traumatic event, the Medical Examiner m	2	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing	Address (Stre	et and Number or	Rural Route Number	er, City or Town, Si	ate, Zip Code)
MD and 2 sho alth and 2 sm 27 is		Marce leine M 20a. Method of Disposition	c Cuy	2/2/ lace of Dispositi	Wirds	or borg	Date 2	A 310 20c. Location - City	by 16. 14. 21207 or Town, State
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E = 0 = - 1		4 Donation 5 Other Specify: 21. Signature of Funeral Service License		e enmour	t Crem	atury Au	9 4 2008	Dalo !	ld.
Balti permit. Departm Importa		Cally C. D	Tue lan	Car	me and Addres	Douglas	Functil Bull	11. 2	1211
Physician		23a. Part I. Enter the disease, or complicate failure. List only one cause on each		Do not enter the	mode of dying	, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interva Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. H	pertensive Cardiovas		se				Death
^		h	e to (or as a consequence of):					
	ner	Sequentially list conditions, if any, leading to immediate Ducause. Enter Underlying Cause	e to (or as a consequence of):		7			
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cuted md transit		d	,			_			
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68760 certificate b iding physi	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregn		il death 3	Ectopic pregn	ancv	23d. Date of deli Month	very Day Year
x 68 th cert	icia	past 12 months?	4 Pregnant at time of dea	-th =	er (Specify)				100.
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COF clawr chasb e 2 sh	mple						autopsy perform	ed? deat	
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should t		25. Was case referred to medical			26.Piac	e of Death (Check	1 Yes 2	NO	Yes 2 No
Vita ysicia his cer direct	o Be		pital: 1 Inpatient 2	ER/Outpatient	_	Othor:		esidence 6 🗸 O	ther: Scene
ing Ph After I	T:U	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Inj		ury at Work?	28d. Describe ho	w injury occurred	
Sior Attend death ctor:	catic	2 Accident 5 Pending Investigation	DO División Alba			Yes 2 No	006 1 10 10		Design to the state of the
Division pital or Attendio	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho (Specify)	me, farm, street	, factory, office	building, etc.	or Town, Sta		Rural Route Number, City
E 8 E E		4 Homicide	: To the best of my knowledg	je, death occurre	ed at the time.	late and place, an	d due to the cause	s) and manner as	stated.
To the Hos within 24 h To the Fur completely	ledical	one) 2 Medical Examiner: 0	n the basis of examination ar						
F % F 8	Me	29b. Signature and title of certifier				se number		29d. Date signed	(Month, Day, Year)
		Donne Int	NO		0.0	.M.E.		July 31, 2008	

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

State 31. Date filed (Month, Day, Year) istrar

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD Assistant Medical Examiner

32 Registrar's Signature

ture Analy

111 Penn Street, Baltimore, MD 21201

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedept's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 4,2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deathy ALTIMORE pita 05 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 1 □ M 2 💢 F Months Days Hours 577-64-5403 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinan must be neathered at Director MI Yes 2 No RID 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giv Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No \$ Specify: Specify: U 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Dhone Derator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SmiTH+ VI LIDRED MITELD ပ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau BWOH44 nangs 6636 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of commetery, crematory or other place Date 1 Burial 2 Cremation 3 Removal from State etw Cremator 4 □ Donation 5 □ Other (Specify) MARYLANG 21. Signature of Funeral Service Licensee 0 tewel LIBERTY Salizo 21207 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ACUTE MYCCARDIAL INFARCTION LOLIZ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ending physician and use as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical attending IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy jo Month Year Day 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has ! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 □ Yes 2 No 2 🗆 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No filled in by the 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22648 30. Naloc and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

I. SNYDER

miD

DHMH 17 Rev 1/2001

ORIGINAL

AUENUE BALTIMORE MARYLAND 27229

900 SOUTH CATON

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Blackwel JULY 30, 2008 4: (0 A M DSEPH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL SAINT AGNES BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-25-1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 82 Months 210-14-9536 **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, It & Modical Examples or putfled at BALTIMORE Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1126 USF by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importants If item 27 Is marked other than "natural", or Itea any Injury or other traumatic event, Ite Modical Exaction any Injury or other traumatic event, Ite Modical Exaction any Injury or other traumatic event, Ite Modical Exaction and Once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Opllege (1-4or 5+) Mangger 50 vernman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blackwell Kina ALICE Verrin ဂ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LITH Blackwell 4201 Chatham Rs Balto . mo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 0804-2008 MARyland VOODLAWA 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hovel Bà no. BERTY 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 DAYS CARDIOMYOPATHI /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, iis certificate has been signed by the attending physician director, page 2 should be detached for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1 □Yes **Division of Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA ၉ completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 MNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

JOSEPH

BLACKWELL

State

Registrar

900 RATONAUE, BALTIMORE MD KONSTANTIN ZUBELEVATSKIY 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P20656

JULY 30, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Allen Dale Bolyard 7/30/2008 6:25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Heritage Center Dundalk Baltimore 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 4/5/1928 7. Age (In yrs. last birthday) **Funeral** Days Min. 1.2 M 2□ F 233-46-7671 80 WV Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Madical Examiner must be notified at MD Baltimore Sparks 1 ☐ Yes 2√No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 16558 Cedar Grove Rd. 21152 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Ses 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🐪 o Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ ivorced mea Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) i 2 should be filed within in and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy B. Bolyard Lenna F. Runner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is 1 any injury or other trausonce. Gerald Bolyard/brother 16558 Cedar Grove Rd. Sparks, MD 21152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Scremation 3 ☐ Removal from State 8/1/2008 |Beltsville, MD Chesapeake Crem. 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility CAFA/Stephen D. Lohrmann P.A. 21. Signature of Funeral Service Licensee 101 Pastures Dr. Towson. MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one caus, if each line. Approximate Interval Betweei Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and I-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): g physician a Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. P. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to dical examiner? director, Be 26. Place of (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manny f Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation To the Hospital or Attending 1 atural Injury within 24 hours after voc....

To the Funeral Director: Aft 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 0 1

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Ma	ryland / [Department	t of H	lealth a	and Me	ental Hy	giene		
			State Registrar		Certificate	e of L	Death			Reg. No. 2	200	24775
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2	2. Date of De Month,	ath Day	Year (3. Time of Death
1	/Medic			Braun					JULY	21	2008	CT:30 M
	Examin	er	4a. Facility Name (If not institution, give street and number)	. 0 - 1			Location of	Death			ty of Death	
	Francis		DALTIMOKE WASHINGTON VEDIC 5. Social Security Number 6. Sex 7. Age	(In yrs. last bird	TER thday) If Under	سان Year I	If Under	24 Hrs. 1 8	Date of Bir	HN		RUNSEL place (State or Foreign
	Funeral Director		216-24-6649 1☑M 2□F		Yrs. Months	Days	Hours	Min.	B. Date of Bir (Month, Da March	iv, Yea <i>r)</i> 10 1928	Coul	ntry) MD
	ס		Usual Residence of Decedent									
	ırylan show	_	10a. State 10b. County	10c. City, Town	or Location						1	0d. Inside City Limits
	Ba-f	5	Maryland Anne Arundel				saden	ıa				1 ☐ Yes 2 ☑ No
	vith th	Öğ	10e. Street and Number		10f. Zip	Code				10g. Citizen o		ntry?
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, Ite Marical Examination relitied at	Funeral Director	113 Cloverhill Road		10.14/ 0	1 - ()	211			1=	USA	
40	ter de Item	E	11. Marital Status 1 □ Never Married 2 ☑ Married 12. Was Decedent E Armed Forces? 1 □ Yes 2 □ N		13. Was Decede	ify Cuba	n, Mexicar	igin? (Spec n, Puerto Ri	ity Yes or No ican, etc.)	- 14. R	ace - Americ ack, White,	
5 甘. 21215-0036	urs af	ğ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ Number of Number 1 ☐ Yes 2 ☐ Number of Number 1 ☐ Yes 2 ☐ Number of Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 2 ☐ Number 1 ☐ Yes 3 ☐ Yes 3 ☐ Ye	Ĭ950-	1 □Yes 2	No	Specify:			Spec	cify: V	White
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and and	2 should be filed and Mental Hygi is marked other aumatic event, II	Be	17. Father's Name (First, Middle, Last) Charles H. Braun							Maiden Surna	ame)	
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Division of Vital Records,	or At after of Direct in by	Certification: To	4 Homicide determined 28e. Place of Injurbuilding, etc.	y - At home, far (Specify)	m, street, factory,	office		28	f. Location (5 City or Tov	Street and Nur vn, State)	nber or Rura	Il Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certii within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner stat	examination and	d/or investigation,	in my op	pinion, dea	th occurred	at the time,	date and place	e, and due to	the cause(s)
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	, 1		30. Name and address of person who completed cause of de	ath (Item 23a) (Type, Print)	- Ju	en læc	نف و	11/25	MID	-	1 Cole u
6	11		Baltimore Washington	Medic	al Cer	ate	V	301	Hos	pital	Drive	Burnie
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 Margaret /Medical DMar 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTI MORE imoni If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Days Hours Min 220-34-5465 Director Nashville Usual Residence of Decedent death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the five fice Examinate by marified at any injury or other traumatic event, the five fice Examinate by marified at appear. 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD 1 Yes 2 No BALTI MORE Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 21093 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes _ 2 __No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No If Yes, Give Year or Dates: ģ Specify Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Kichard SON ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oaklyn Wende timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Frans tureral Chapel FORIST Hill 21. Signature of Funeral Service Lice FORST HILL 21050. Kinber Councition SericEs-BOLAIR or som lica ions that caused the death. Do not enter the mode of dying, such as cardiad or respiratory arrest, list only one lause on act line. 23a. Part 1. Enter the sease shock, or hear failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ears Due to or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has The certificate performe 1 □Yes 2 X No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: AND Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 3completely f (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 06

Registrar
DHMH 17 Rev 1/2001

JULY

MARGARET

CHAPMAN

2300 DULANEY VALLEY ROAD

TIMONIUM

21093

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

ERNESTINE WRIGHT,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2008 July 30, **Physician** Wayne Dewey Crenshaw 1:25 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 951 Lance Avenue Essex Baltimore 8. Date of Birth Month, Day, Year) 11/20/1928 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**/2** MM 2 □ F Months Days Hours Min. South Carolina 247-40-5917 79 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural" ~ " any hjury or other traumatic even." 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 277No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 951 Lance Avenue 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1945-1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2XXNo Specify: Specify: White ð 1946 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Utility Man General Motors Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Olin C. Crenshaw Mattie Kelley ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Crenshaw (Wife) 951 Lance Avenue, Baltimore, Maryland 21221 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard. 08/02/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final disease condition resulting in death) Physician /Medical ressive Glomenlone phritis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed and burial-trai resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, the attending physician ned for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 ☐ Yes ≥ ☐ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 2 No 1 □Yes 2 🔽 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Hospital: 1 Tes 2 No 2 TER/Outpatient 3 DOA Certification: To 1 Inpatient 5 Residence 6 ☐ Other (Specify) To the Funeral Director After this completely filled in by the funeral dil 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 ☐ Accident 5 Pending investigation a er death. 1 ☐ Yes 2 🗆 No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital Medical 29a. Certifier tx Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature D61907 10+1 cause of death (Item 23a) (Type, Print) Bultimore, MD 21221 KWUMA U 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AMIRCIS NUISIMS CENTER BULIS LUNDEL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X F Months Days Hours Min. Director 44 10-21-1963 194-54-4866 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at Director XXYes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 922 CHAUNCEY AVENUE 21217 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify. þ Specify 3 Widowed 4 Divorced BLACK "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. filed withir Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DIETARY ASSISTANT NUTRITION 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES O. CARTER YVONNE REGIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LANITA ROSS/ AUNT 922 CHAUNCEY AVENUE BALTIMORE, MARYLAND 21217 Department of Heal Important: If item 2 any injury or other 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-2-2008 BALTIMORE, MARYLAND METRO CREMATORY ature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21217 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** WMIL /MAULODEFICIENCE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending properties for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. | signed by the a 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 1No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1. Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Varnum 1160

31. Date filed (Month, Day, Year) 2008

29b. Signature and title of certifier

State

29c. License number

10026004

	•	For State Of Wal	•	artment of Health rtificate of Deat		Reg. No.				
Physicia /Medic Examin Funeral Director	an al er	1. Decedent's Name (First, Middle, Last) LORRAINE Crea 4a. Facility Name (If not institution, give street and number) FUTURE CAVE LRUIN	Ger 1940N (In yrs. last birthday) Yrs.	4b. City, Town, or Location A Creation of Control of C	er 24 Hrs. 8. Date of B	Day Ye 36 C 4c. County of D	Death More Cito Birthplace (State or Foreig Country)			
with the Maryland e or 28e-f show	tor	10a. State 10b. County	10c. City, Town or Lo Baltimon			10d. Inside City Limit				
uth with the 23e or 28e ust be noti	i Director	10e. Street and Number 22 South Athol Ave		10f. Zip Code 21229		10g. Citizen of What	t Country?			
after dea or Items	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ▼ No. If Yes, Give Year or Dates:)	Was Decedent of Hispanic (If Yes, specify Cuban, Mexic 1 ☐ Yes 2 No Speci		1	American Indian, Vhite, etc. Vhite			
a filed within 72 hours I Hygiene, other than "natural" rent, I e Medical Ex	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-4)	ilte.	dent's Usual Occupation kind of work done during m DO NOT use retired)	16b. Kind of Busine	·				
d la la la la la la la la la la la la la	o Be C	17. Father's Name (First, Middle, Last) Louis Kordek	120 MOI	18. Mo	ther's Name (First, Middle:ie Unknow	le, Maiden Sumame)				
and 2 should Balth and Men n 27 is marke ier traumatic		19a. Informant's Name/Relationship (Type, Print) Michael T. Creager/son	19b. Maili 728	ng Address (Street and Num Rively Ave.	Glenolde	ther, City or Town, Staten, PA 19	te, Zip Code) 036			
Pages 1 nent of Ha ant: If iter ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Sremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1 -	osition (Name of matory or other place) ake Crem.	Date 8/1/2008	20c. Location - City Beltsvi				
permit. Departr Imports eny Inje		21. Signature of Funeral Service Licensee MOI	443 87	2. Name and Address of Fac 717 Green P	Stephen lastures D	D. Lohrma r. Baltin	nn P.A.CA			
Physician /Medical Examiner B physician and as the partial-transit as the partial-transit as the partial-transit as the partial as the parti	sical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cause of into) that mittated events c.	ð.	er the mode of dying, such	as cardiac or respiratory	allest,	Approximate Interval Between Onset and Death			
The law requires that the death certificate to has been signed by the attending physoage 2 should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date Month of the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Fetal death 5 Other (specify) Month of the past 12 months? 1 Live birth 2 Live birth 2 Live birth 2 Live birth 2 Live birth 2 Live birth 3 Live birth 2 Live birth 3 Live birth 3 Live birth 4 Live birth 3 Live birth 4 Live								
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	Completed	Rheyma hold Gr. Hari, hs 24a. Was an autopsy performed? 1 yes 220 No 11								
Hospital or Attending Physician: The hours after death. Funeral Director: After this certificate tely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1								
pital or Anurs after of eral Directilled in by	i Certif	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mar								
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1	examination and/or in	29c. License number	eath occurred at the time	e cause(s) and manne e, date and place, and 29d. Date signed (M	due to the cause(s) fonth, Day, Year)			
5		30. Name and address of person who completed cause of de Rayesh Shah : 821 N Enter S			MD 2120		,			
1		31. Date filed (Month, Day, Year) a32. Registra		,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 30,2008 Month July Matthew Н 2:20 AM Curley 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Baltimore 8102 Holly Road If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 1 🔀 M 2 🗆 F 215-28-6457 June 29 1931 Baltimore Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Anne Arundel Baltimore 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8102 Holly Road 21226 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 □ No 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) warehouse man Truck Parts 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Matthew J Curley Marquerite 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jacqueline J Curley spouse 8102 Holly Road Baltimore MD 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1∑Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery | Aug. 1,2008 Glen Burnie Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lie Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 Approximate Interval Between Onset and Death Part . Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List oply one cause on each line. Immediate Cause (Final

Department of Health and Mental h Important: If Item 27 Is mar-any injury or other Physician /Medical Examiner

the attending physician and hed for use as the burial-trar

signed by the a d be detached for

page 2 should certificate has been

director,

filled in by

completely

After this funeral

To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

requires that the death certificate be executed

Box 68760,

P.O.

Division or Vital Records,

Physician

/Medical

Examiner

10a. State

Funeral

Director

"natural", or Items 23a or 28a-f show sdical Examiner must be notifled at

the Medical

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al Hygiena.

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Director

Funeral

Completed by

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Examiner

Physician/Medical

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Certification:

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State

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

disease or condition resulting in death)

umphemo Due to (or as a consequence of Due to (or as a consequence of)

Due to (or as a consequence of)

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes

24a. Was an autopsy 1□ Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 ☐ No မ

27. Manner of Death 1 Natural 2 Accident

5 Pending investigation 6 ☐ Could not be

2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

lace of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

NA

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24 A Magothe

Janse

32. Registrar's Signature

31. Date filed (Month, Day, Year) AUG 0 2008 Beach Rd Pasadena, MD 21122

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar		State o	f Marylan			of Health of Deat			iene 0	08	24781	
	1. Decedent's Name (First, Middle, Last) Physician /Medical BEATRICE							DA	VIS	2	Date of Dear	Day 29. 2008 6 10 M			
	Examin		,	f not institution, give		mber) NURSING		4b. City, Town, or Location of Death BALTIMORE				4c. County of Death BALTIMORE			
	Funeral Director		5. Social Security N 212-20-	·9480 ^{1[}	х Эм 2 X) F	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Months	Year If Und Days Hour	er 24 Hrs. 8 s Min.		1925	9. Birthpl Coun	lace (State or Foreign fry) MD	
	with the Maryland a or 28s-f show the notified at	tor	Usual Residence of 10a. State MD	10b. County BALTIN	10RE		y, Town or Lo						10	0d. Inside City Limits 1 ☐ Yes 2 🕅 No	
	h with the 23a or 28a at be noti	al Director	10e. Street and Nur	L	•			10f. Zip C	2120	9	1	0g. Citizen of \	What Coun	try?	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mantal Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28a-f show eny injury or other traumatic event, the Madical Examinating the notified at once.	by Funeral	11. Marital Status	ied 2□ Married		2 X No	1	Was Decede f Yes, specif 1 ☐ Yes 2	nt of Hispanic y Cuban, Mexi No Spec		fy Yes or No- can, etc.)		ce - Americ ck, White, o		
21215-0036	within 72 ho ene. then "natur he Medical I	Completed	(Spec	15. Decedent's Ed cify only highest grad endary (0-12)			(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY					usiness/Ind	dustry AILROAD	
and 2	id be filed ental Hygi ked other c event, II	To Be Co	17. Father's Name	(First, Middle, Last)	•		DAV		18. Mo	other's Name (First, Middle,		aiden Surname) ROSEN		
Maryland	and 2 should belth and Men n 27 is marke her traumatic	-	19a. Informant's N	ame/Relationship (7		TER	19b. Maili	ng Address (Street and Nur	nber or Rural		r, City or Town,	State, Zip		
Baltimore,	. Pages 1 a tment of He tant: If Item jury or other			position Cremation 3 5 Other (Specify			Place of Disposition Report Fig. 19 ANSHE	SETH "T SFARD	SRAEL	08/01/		20c. Location -			
Balt	permit. Departr Importa		Med	uneral Service Licen				8900 F		STOWN F	ROAD -			MD 21208	
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0 0	4 2 B												ne cause of death?		
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Vita	yeicien is certifi director	o Be	25. Was case reference examiner? 1 Tes 2		Hospital:	Inpatient 2	FR/Outpatie	nt 3 DO/	Other	ace of Death		he) lence 6 □Otl	har (Specif	ivl	
n of	Attending Physicien: r death. sctor: After this certific by the funeral director.	 -	27. Manner of Dea	th 5 Pending	28a. Date (Mod	of Injury nth, Day Year)	28b. Time of Injury	of 28	c. Injury at Work?	28		ow injury occur		<i>''</i>	
Divisio	To the Hospital or Attand within 24 hours after death To the Funaral Director; completely filled in by the f	Certification:	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	28e. Plac	e of Injury - At h ding, etc. <i>(Speci</i>	ome, farm, si	M reet, factory,	1 Yes 2		Bf. Location (S City or Tow		ber or Rura	al Route Number,	
	ne Hospital 24 hours a ne Funaral D	Medical C	29a. Certifier (Check only one)	1 ☐ Certifying Ph 2 ☐ Medical Exam	niner: On the										
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	Sta Regist	ate rar	31. Date filed (Mo	nth, Day, Year) UG 0 1 20	08	Registrar's Sign	ature	BALL!							

08-05707 Ricky Carlos Dumpit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Carlos Dump	1 . F	- For State egistrar	te of Maryla		ertment of tificate of			Mental I		Reg. N	20	008	3 2	47
Physician/ al Examine	Т	1. Decedent's Name (First, Middle, RICKY CARLOS	DUMPI						2. Date of D Month July 25,	2008			3. Time of E 0847 h	
	ľ		la. Facility Name (if not institution, give street and number) Prince George's Hopital Center						ath			c. County of Death Prince George's		
Funeral Director		· ·	5. Sex 1 X M 2 F	7. Age (In yrs. la	ast birthday) Yrs.	If Under Months		If Under 24H Hours M	8. Date of 05-2		м/dd/үүүү) .962	Foreign		e or
ow any	ľ	Usual Residence of Decedent 10a. State 10b. County MD PRINCE	GEORGE'	1	Town or Locati	on						T	10d. Inside	_
the Maryland a or 28a-f sh tiffed at once		10e. Street and Number	LVLKDI					10g.	Citizen of Wha	at Count	-			
23a or	5	2204 CHEVERLY A			·	207				US				
Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Montal Hygievier and in Health and Montal Hygievier has "natural", or items 23a or 28a-f she mit. If items 27 is marked other than "natural", or items 25a or 28a-f she in other traumatic event, the Medical Examiner must be notified at once ir other traumatic event, the Medical Examiner must be notified at once ir other traumatal Direction		11. Marital Status 1 X Never Married 2 Mar 3 Widowed 4 Divor	ried Armed F	2 X No	If Y		Cuban, I	Mexican, Pue	Specify Yes or rto Rican, etc.)	No-	14. Race - White, Specify: F	etc. WH	an Indian, E ITE	Black,
tygiene. other than "natural" the Medical Examine	neted by	15. Decedent's Education (Speci- Elementary/Secondary (0-12)	16a. Deceden	t's Usual O	ccupatio			16	b. Kind of Bus					
Hygiene. other the the Medi		12TH 17. Father's Name (First, Middle, L	act)		SANIT	ATION			me (First, Middl	o Mais	PRIVA	TE		
permit; Pages I and 2 should be filed with Department of Health and Mental Hygiene Department I fitten if 27 is marked other I injury or other traumatic event, the Med To Be Comm		MARIANO DUMPIT	.ast)				10		ME (FIRST, MIDDA ARET BUF					
d Ment d Ment s mark tic ever		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailing	Address	(Street a		or Rural Route	_		, State,	Zip Code)	
d 2 sh kh anc n 27 is	L	DARLENE DUMPIT	/ SISTER					AVENUE			Y, MD	20		
s l an of Hea If iten		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal fr		Place of Dispos crematory or oth		e of ceme	etery,	Date	20	Oc. Location - (City or 1	Fown, State	
Page ment c tant: or oth		4 Donation 5 Other Spe	ecify:		SHINGTO				-02-200		SUITLA			
permit Depart Impor Injury		21. Signature of Pineral Service L		LD R. G				Facility N AND RO	1ARSHALI		FUNERA		OME OF 2074	
ysician Medical caminer		or condition resulting in death) Seguentially list conditions. Due to (or as a consequence of): b.										ate Inter Onset a eath		
cuted und transit														
be exe	8 E	X UNPENDED	AMENDED	23a,PII	,27,per	ME,g8	82 8	/4/08	TT					
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death, which lay the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the benefit of attending the funeral director, page 2 should be detached for use as the benefit of certification: To Be Computated by Diversification.	ly sician/ine	FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1												
signed by the bedetache	6	Disheton mollitus									bbacco use contribute to the cause of death?			
The law requires ficate has been significate has been significate by page 2 should be	ompiete								_ _ pe	as an utopsy erforme es 2	pr d? de		topsy finding ompletion of s 2	
ysician: The his certificate director, page		25. Was case referred to medical examiner?	Hospital.					f Death (Che	ck only one)					
iding Physia h. : After this e funeral dir	٩.	1 Yes 2 No 27. Manner of Death	(Mont	Inpatient 2 e of Injury h, Day,Year)	ER/Outpatient		Bc. Injury	at Work?	28d. Descri		sidence 6	Other	:	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	eruncat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Loc								on (Stre	et and Numbe e)	er or Rui	ral Route Nu	umber, (
To the Hospital or within 24 hours after To the Funeral Div completely filled in Lodical Cortifi	Medical	20a Certifier	ysician: To the be niner: On the basis and manner	of examination a										
- × + 0 2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, July 26, 2008								nth, Day, Yea	ar)				
\emptyset		30. Name and address of person values Tasha Greenberg MD.		/ledical Exam	niner 111		reet, E	altimore,	MD 21201				110	
Stat Registra	te	31. Date filed (Month, Day Year)	08 A32.R	tegistrar's Signat	ure	مر								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland State of Maryland State	d / Department of Health and M Certificate of Death	lental Hygien	/11118 /4/83
ja ja	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) Ruth 4a. Facility Name (If not institution, give street and number)	R. Davis 4b. City, Town, or Location of Death	2. Date of Death Month Da July 2	ay Zood 2:30 Am County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1) 215-03-3873	Baltimore Wast birthday) If Under 1 Year Months Days Hours Min.	8. Date of Birth (Month, Day, Year, Jan 5, 191	Baltimore City 9. Birthplace (State or Foreign Country) Baltimore, MD
	Maryland a-f show	ctor		7. Town or Location 1timore		10d. Inside City Limits 1 ⊠Yes 2 □ No
36	hours efter death with the Maryland tural; or Iteme 23e or 28e-f show at Examinat must be rudified at	by Funeral Director	10e. Street and Number 3300 Benson Ave, apt 211 11. Maritat Status 1★ Never Married 2 Married 3 Widowed 4 Divorced 1 1 Yes 2★ No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	UŞ	itizen of What Country? SA 14. Race - American Indian, Black, White, etc. Specify:White
21215-0036	within 72 ene. than "nai	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Medical secretary	ing	Kind of Business/Industry
Maryland 2		To Be Co	17. Father's Name (First, Middle, Last) Ray Sands Davis	18. Mother's Name	e (First, Middle, Maide) Rauch	
	1 and 2 s Health ar om 27 is ther trau		19a. Informant's Name/Relationship (Type, Print) Barbara Ordakowski - friend 20a. Method of Disposition 20b. P	19b. Mailing Address (Street and Number or Run. 11160 Chambers Ct, Un: lace of Disposition (Name of emetery, crematory or other place)	it M3, Wood	
altimore,	permit Peges Department of Important: If it any injury or o		I Li buriar 2 Micremation 3 Li hemovarironi state	roll Cremation 7/30	-	ostead, MD
	Physician		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Eline Funeral Home n. Do not enter the mode of dying, such as cardiac	Reisterst	Approximate the three and Death Onset and Death
*	/Medical Examiner).	resulting in death) Due to (or as a consequentially list conditions, if any, leading to immediate Due to (or as a consequentially list conditions).	deina		1 month
7,097	ate be executed hysiclen and he burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence)	YPOXIA		1 month
О. Вох 68	death certific e attending pl ed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. tf yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	I death 3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
Records, P.	law requires thet the de es been signed by the a 2 should be detached f	þ	Part II. Other significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions contributing to death but not result in the significant conditions c	ulting in the underlying cause given in Part I.		use contribute to the cause of death?
	The ete h page	Completed	25. Was case referred to medical		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
ion of Vital	Physici this ceral direc	ation; To Be	examiner?		h (Check only one) me 5 ☐ Residence 28d. Describe how inju	
Division	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	Certification;	3 Suicide 6 Could not be determined 28e. Ptace of Injury : At his building, etc. (Specify		City or Town, Stat	
	To the Hospitel or within 24 hours after To the Funerel Direct completely filled in b	Medical	29a. Certifier (Check only onle) 2 Medical Examiner: On the basis of examina and manner stated. 29b. Signature and title of certifier	wledge, death occurred at the time, date and place, tion and/or investigation, in my opinion, death occur	red at the time, date ar	s) and manner as stated. Individual place, and due to the cause(s) ate signed (Month, Day, Year)
)	F 3 F 8		30. Name and address of person who completed cause of death (Item	- 1 41640		ly 29, 2008 yland 21227
) Sta		Ming Vi MM 3320 (Longon Signature Completed Satisfy Beginstrar's Signature Completed Satisfy Beginstrar's Signature Completed Satisfy Beginstrar's Signature Completed Satisfy Beginstrar's Signature Completed Satisfy Beginstrar's Signature Completed Satisfy Beginstrar's Signature Completed Satisfy Beginstrar's Signature Completed Satisfy Beginstrary Signature Completed Satisfy Beginstrary Satisfy Beginstrary Signature Completed Satisfy Begins Begins Beg	Avenue Baltimo	re Mar	yland 21227
	Registi	ar	Hou v 4	d.		

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, ospital or Attending Physician: The law requires that the death certificate be executed bours after death.

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		1 - For State of Maryland / Departm Certific						artment of F r <i>tificate of</i>						
		Decedent's Name	e (First, Middle,	Last)						2. Date of De	ite of Death 3. Time of Deat			
Physicia /Medic		NANEZUNA						DRIZO		JULY	28 2	2008	9:30P M	
Examin		4a. Facility Name (I							r Location of Dea	th	4c. Cour	nty of Death		
		SINAI HOSPITAL OF BALTIMOR 5. Social Security Number 6. Sex 7. Age					last birthday)	BALT IMOF		8. Date of Bir	th	N/A	place (State or Foreign	
Funeral Director		216-37-0734 1□M 2X1F			88	Yrs.	Months Days	Hours Min	09/1	5, Year) 5, 1919	Cour	UKRAINE		
and ow		Usual Residence of Decedent 10a. State 10b. County				10c. City	y, Town or Lo	cation					0d. Inside City Limits	
Mary	tor	MD					BALTIM	ORF			1 X Yes 2 □ No			
th the	Director	10e. Street and Nur					37(2111	10f. Zip Code			10g. Citizen of What Country?			
ath wi		5900 PA	RK HEIGH	HTS AV	ENUE,						USA			
filed within 72 hours after death with the Maryland Hygiene. Hygiene, ther than "natural", or items 23a or 28a-f show ant, the Predicel Examination of the redified at	by Funeral		11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Armed Forces: 1 □ Yes 2 □ If Yes, Give Year or Dates:			Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric				Specify Yes or No to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE			
72 ho	eted	15. Decedent's Education (Specify only highest grade completed)						dent's Usual Occup		rkina	16b. Kind of	16b. Kind of Business/Industry		
within 72 hours ene. than "natural", he Medical Ex.	Completed	Elementary/Seco			ege (1-4or 5	i+)	`life.	DO NOT use retire	d) KEEPER	. N	MANUFACTURING			
e filed withi al Hygiene. I other than vent, ine I		17. Father's Name	(First, Middle, La	ıst)				DOOKI		me (First, Middle				
ouid be to Mental arked o atic eve	To Be	NUCHAM					DR	IZO	SON	/A	KHAIT			
2 should be and Mental is marked of raumatic ev		19a. Informant's Na	ame/Relationship	(Type. Prin	t)		19b. Maili	ng Address (Street	and Number or F	ural Route Numb	er, City or Tow	ın, State, Zip	Code)	
ges 1 and 2 should be filed within 72 ho to the latte and Mental Hygiene. If idem 27 is marked other than "natur or other traumatic event, it a prodical			SCHWART	Z / SO	N			6 ROUNDWO						
permit. Pages 1 and 2 D. partment of Health & Important: If item 27 is any injury or other tra			position □ Cremation 3 5 □ Other <i>(Spe</i>		from State	20b. P	Place of Dispo emetery created HIZIR	sition (Name of patony of other pla AMUNO	ce) 07/3	Date 80/2008	20c. Location	n - City or To		
mit. F partm portar / Injur	}	21. Signature of Fu			1	01		2. Name and Addre		SOL LEVI				
27 2 2 2		Va	Tatukk Sam 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208											
Physician		23a. Part 1. Enter the shock, or hea Immediate Cause (disease or condition	rt failure. List or (Final	one cause	that cause e on each lin	the death	h. Do not en	er the mode of dyi	ng, such as cardia	ac or respiratory a	ırrest,		Approximate Interval Between Onset and Death	
/Medical Examiner		resulting in death)	1	a	ue to (or as	a consequ	ence of):	monia						
executed in and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.												
ocia our		Due to (or as a consequence of):												
tificate g phy as the	edic			d				1			1			
To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. with the Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the L	Physician/Medical							☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date of delivery Month Day Year			
To the Hospital or Attending Physician: The law requires that the dividing 42 brours affact death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	ò	Part II. Other significant conditions contributing agree at but not resulting in the underlying cause given in Part I.										he cause of death?		
has bee	Completed	<u> </u>	VOVIC	in	Krun	titi.	of c	7stit.)J	psy	24b. Were autopsy findings available prior to completion of cause of			
an: The tificate or, pa											2 No			
lysich	To Be	examiner? 1 ☐ Yes 2 💢		Hospital:	1 X Inpatie	ent 2 🗆	ER/Outpatie	nt 3 DOA Oth		Home 5 ☐ Res		Other (Specia	fv)	
inding Phath.	ation: T	27. Manner of Deat 1 X Natural 2 Accident	h 5 □ Pending investiga		Date of Inju (Month, Da	ıry ıy, Year)	28b. Time of Injury	Wor			how injury occ			
tal or Atters as after de al Directo ed in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin		Place of Injubuilding, et			eet, factory, office		28f. Location (City or To	(Street and Nui wn, State)	mber or Rur	al Route Number,	
the Hospi iin 24 hou the Funer	edical	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	caminer: Or	To the best the basis of manner sta	of examina	wledge, deat ation and/or in	h occurred at the to estigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time	e cause(s) and , date and plac	manner as se, and due t	stated. o the cause(s)	
vith Con	Ā	29b. Signature and	title of certifier	W	M	20		29c. Licen:	3033	9	29d. Date sign	ned (Month,	Day, Year)	
1		30. Name and addr	NI	ho completed	TET	-14	000	Print) ed	Convo 1	2d; B	allim	ore, l	TO LILOS	
Sta Registra	te ar	31. Date filed (Mon	AUG 0 1	2008	32 Megistr	ar's Signa	iture	nete .				/		

DHMH 17 Rev 1/2001

08-05771	1	Please Type or Print in Black Indelible Ink. Ensure All Copies		ole.
Christopher Mich		1- For State Certificate of Death	giene Reg. 1	2008 2178
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle, Last) Christopher Michael Eckels	Date of Death Month Date July 28, 2008	3. Time of Death
Pr.		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1007 Milchling Drive Belair	131.	4c. County of Death Harford
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs: Months Days Hours Min.	8. Date of Birth (N	/M/DD/YYYY) 9. Birthplace (State or Foreign
Director		219-04-2752 1XM 2F 35 Yrs. Months Days Hours Min. Usual Residence of Decedent	May 11,	1983 Country Mary land
ow any		10a. State 10b. County 10c. City, Town or Location	0	10d. Inside City Limits 1 Yes 2 X No
farylanc	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
(25 (2) or reast with the Maryland or items 23a or 28a-f show must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec		U.S.A.
death w	Funera	11. Marital Status 1		14. Race - American Indian, Black, White, etc.
hours after "natural", o	ā	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 116a. Decedent's Usual Occupation (Give kind of wo	rk done 16	Specify: White
6 72 hou an "nat	leted	Elementary/Secondary (0-12) College (1-4 or 5+)		A 1 D i
215-0036 be filed within 72 hours after death with the Maryland mtal Hygiene. rked other than "natural", or items 23a or 28a-f shi ent, the Medical Examiner must be notified at once	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name (18. Mother	R First, Middle, Maio	Huto Jales den Surname)
Baltimore, MD 21215-0036 permit: Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other trainmatic event, the Medical Examiner.	Be	Timothy Eckels Caro	1 Bus	kirk.
MD 21 d 2 should the and Mer n 27 is maximumatic even	우	19a. Informant's Name/Relati Inship (Type, Print) 19b. Mailing Address (Street and Number or Ru 1007 Milchling (ral Route Number	r, City or Town, State, Zip Code)
ore, les I and of Healt If item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date / 08 20	Oc. Location - City or Town, State
트 다 의 프 노		4 Donation 5 Other Specify: Evans Fune ral Chape + Centation		Forest Hill, MD
Balti permit Departm Imports injury o	1	21. Signature of Funeral Strvice Ligensee EVENTS FUNERAL CHARACTERS OF FACILITY OF THE PROPERTY CHARACTERS OF FUNERAL CHARACTERS OF	sel + Cre	r-orest Hill, MD 21050 mation Sorvices-Bellin
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arrest,	shock, or heart Approximate Interval Between Onset and Death
Examiner (Immediate Caus (Elfal disease or condition resulting in death) a. Narcotic (methadone) intoxication Due to (or as a consequence of):		Death
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	raminer	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
xecuted π and - transit	cal Ex	d	/08 TT	
60, ate be ex hysiciar	an/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy	- 1	23d. Date of delivery
certificate be rading physici	cian/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant	су	Month Day Year
Box ne death c the atten	Physic	1 Yes 2 No 9 Unknown		
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be expected. After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burial-	Ş	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
of Vital Records, ag Physician: The law requiring Physician: The law requiring the this certificate has been simeral director, page 2 should be	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
Rec It The Lifficate H		25. Was case referred to medical 26.Place of Death (Check or	performe	
Vital hysiciar this cer	o Be	examiner?		sidence 6 🗸 Other: Scene
n of nding Pi fh.	ion: Ţ	1 Natural 5 Pending (Month, Day, Year)	28d. Describe how unk	injury occurred
Division tal or Attendir ars after death.	Certification:	2 Accident Investigation Fnd //28/08 Fnd 11:40 am		et and Number or Rural Route Number, City
Division 1 Division 1		29a. Certifier		net and Number or Rural Route Number, City a) 1007 Milchling Dr D
Division To the Hospital or Attent within 24 hours after death To the Fineral Director: completely filled in by the	edical	(Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and done) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.		
F × F 5	Me	29b. Signature and title of certifier 29c. License number O.C.M.E.		9d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)		701y 29, 2000
		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201	
Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** William Flournoy Easter 9:20 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number)
Northwest Hospital Center 4b. City, Town, or Location of Death Randallstown Balltimore Examiner . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral X**□ M 2□ F Months Days Hours Min. 223-56-7380 67 1940 Virgínia Director Nov.1, Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Experiment must be recified at 1XX Yes 2 ☐ No Director Baltimore N/A Maryland 1 and 2 should be filed within 72 hours after death with the Health and Mental Hygiene. 10e. Street and Number 10g. Citizen of What Country? USA 5321 Beaufort Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Maryland 21215-0036 Specif Black 1 □ Yes 2 □ Mo Specify: ģ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Calvert Wholesale College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Florist 12th grade 17. Father's Name (First, Middle, Last) 7 is marked other traumatic event, II 18 Mother's Name (First, Middle, Maiden Surname) Leroy Easter 2 19a. Informant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5321 Beaufort Avenue Baltimore, Maryland Gloria Easter/ Wife permit. Pages 1 and Department of Health important: If item 27 any injury or other tr once. 27 altimore, 21215 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. zion Cemetery Date 20c. Location - City or Town, St 20a. Method of Disposition Lansdowne, Maryland 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/29/08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman. 5240 Reisterstöwn Rd -Harris Funeral Home 21. Signature of Funeral Service Licensee Baltimore, Maryland 21215 ario 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Kana disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner sician and burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Year 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. þ sign be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1∐Yes 2∭No 1 TYes After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) SLASONS Other: 4 ☐ Nursing Home 5 ☐ Residence 6 😿 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To HOSPICE Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director; A 2 Accident investigation filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a, Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 251/ 1+45931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERSTOWN MP) courch 25 MAN Year) 31. Date filed (Month, Day, 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** 3^{Day} 2008 5:45a M Carlton W. Evans /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 333 Margaret Avenue Essex If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours 1**☑** M 2□ F New York 216-18-3552 Dec.11,1921 Director 86 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Baltimore Essex 1 ☐ Yes 🏖 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 USA 333 MArgaret Avenue Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 █**X**No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Electrician 8th permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygid Important: If item 27 is marked other if any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin W. Evans Teressa A. Pryne ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Evans /son 333 MArgaret Avenue Baltimore MD 21221 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Holly Hill Cemetery 8/4/08 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 1/5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. BAlto. MD Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. PartT. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** Chonie 555 March disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to influed accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the aid 1 ☐ Yes 2 ☐ No Ö 9 Unknown ص 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Teath 28h Time of 28c. Injury at Work? 28d. Describe flow injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

82. Registrar's Signature

and manner stated.

SCHLUEDERREPU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Medical

Sectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00076951

GIIY Philadelphia Ry, such 128

29d. Date signed (Month, Day, Year)

Amend 20b, per Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 **Physician** Mary Elizabeth Noyes Eliot 29, 0500 M July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital
5. Social Security Number | 6. Sex | 7. Ana // Montgomery 01ney 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2**X**X Months Days Hours Min Director OCT 24, 1919 213-50-8537 Cuba Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2XXNo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 15100 Interlachen Dr. #521 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian ent of Health and Mental Hygiene.

ti fillem 27 is marked other than "nature." 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes ACTNo Specify Š Specify. 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 200c. 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Brice Carlos Faber Noyes ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22031 9138 Leghorn Pl. Fairfax, VA Christine E. Connell/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 7/31/2008 Beltsville, MD 21. Signature of Funeral Service Licensee RANGE THE STORY OF SERVICE STREET OF SV. 935 Gist Ave. Silver Spring, 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COPD SEVERE /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Uncertee of high that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, 3 Physician/Medical attending physi IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown à been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1XYes 2 No 3 Probably 4 Unknown HIP FRACTURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, page 2 autopsy perform certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No Certification: To 1 Phopatient 2 ☐ ER/Outpatient 3 ☐ DOA this completely filled in by the funeral 27. anner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 Natural 5 Pending AM 1 ☐ Yes 2 No AND s after death 2DAccident investigation 26/2008 TRIP 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide SILVER SPRING HOME 15100 INTERLACHIN DR. 24 hours a MALYLAND 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRINCE PHILIP DR GOMA M.D. OLNEY MD 20832 MONIQUE 18101 31. Date filed (Month, Day, 1Year) 008 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day JULY 29, Bertha Eloise Ford 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 □ M 2 1 F 86 213-20-2151 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Maryland Baltimore County Perry Hall 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9502 Amberleigh Lane 21128 United States 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No White Specify: Specify: 3 → Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College, (1-4or 5+) Elementary/Secondary (0-12) Blue Print Tech. Koppers Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Frances Simms John Christian Frisch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9502 Amberleigh Lane Mr. Larry A. Ford (Son) Perry Hall, Maryland 21128 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. 20c. Location - City or Town, State 20a. Method of Disposition Date Aug. 0. 2008 04, 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland L. Gair) Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee Jeffrey ations th Approximate Interval Between Onset and Death 23a. Part / inter he riseas of complications the shoot, or hearth illure. Lift only one cause sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) watery Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner The law requires that the death certificate be executed

Examine

Physician/Medical

2

Completed

Be

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Certification:

Medical

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene.

permit. Pages 1 and 2 should be flied will Department of Health and Mental Hygien. Important: If them 27 is marked other than any injury or other traumasts.

Funeral

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Completed

Be

attending physician

Hospital or Attending Physician: 24 hours after death. Funeral Director; After this certifical in by the funeral

Division or Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No 9 Unknown

28b. Time of

27. May r of Death 5 ☐ Pending investigation Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of per who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year) State 2008 AUG 0

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To the Hospital within 24 hours a To the Funeral C

			State of Maryland / Department of Health and Mental Hygiene
			= State Registrar Certificate of Death Reg. No. 2008 24790
b	Dhi-i	恢	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death
	Physici /Medic		HAROLD JEROME FLOWERS JULY 27 2008 7:59 A M
}	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
4	<u> </u>	* 1	WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Funeral Director		229-38-2193 1 M 2 F 73 1 M Onths Days Hours Min. (Month, Day, Year) AUG 16, 1934 MD
ela:			Usual Residence of Decedent
	ırylan show d at	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 11€ 2 □ No
	Ba-f s	Director	MD PRINCE GEORGE'S CAPITOL HEIGHTS
	with the		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	ns 23 must	Funeral	4109 SHELL STREET 20743 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
0	r iten riner	ᇤ	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1952 1 N
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Hygiene. did Hygiene. did other than "natural", or items 23a or 28a-f show dither than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates TO 1956 In Yes 2 No Specify: Specify: Specify: BLACK
2	72 hc 'natu dical	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
121	within ene. than '	ld m	Elementary/Secondary (0-12) College (1-4or 5+)
2	filed within 72 Hygiene. hther than "nat ent, the Medic		12th Mail Room Supervisor White House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
an	should be filed id Mental Hygi marked other matic event, t	To Be	Frederick Flowers Mary Dameron
ary	2 should be filed vand Mental Hygie Is marked other fammatic event, the		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	ges 1 and 2 should t of Health and Mer if Item 27 is marke or other traumatic		Evelyn Jean Flowers / Wife 4109 Shell Street Capitol Heights, MD 20743
altimore,	ges 1 it of He if Iten or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Ĕ	Pa nen nint; lint;		4 □ Donation 5 □ Other (Specify) Harmony Memorial Park 08-02-2008 Landover, MD
Bai	permit. Departn Imports any inju		21. Signature of Funeral Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD Donald R. Gray 4308 SUITLAND ROAD SUITLAND, MD 20746
	40200		Donald R. Gray 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
		8	shock, or heart failure. List only one cause on each line. Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
	Examiner		
	7 A A	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
p.	ecuter ind transi	Examiner	that initiated events c
.09	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		Due to (or as a consequence of):
8	physic	dical	d
9 X	leath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 23d. Date of delivery
Box	atten after I for u	ciar	23b. Was decedent pregnant in the past 12 months? 1
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a, D	ires that the de signed by the a be detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Records,	w require been signature should b	ed k	Chron Te Ilehal Injufficiency 1 Yes 2 No 3 Probably 4 Driknown
ပ္ပ	e law r has be je 2 sh	ple	Cevehual Infraction Right Henrin 41 Kis 24a. Was an autopsy findings available prior to completion of cause of
_	The	Completed by	Coronary Gutery Disease Pacamaken - Defibrilly To 1 yes 2 10 1 yes 2 No
Vital	hysiclan: The Is his certificate ha: I director, page 2	Be	25. Was case referred to medical examiner? Hospital: Other: Othe
0	Phys	٦.	1 Inpatient 2 Feb. Voutpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)
on	iding Ph h. After thi funeral	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 28b. Injury 28b
Division or	or Attence after death Director: in by the	fica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
á	al or At s after d al Direct ed in by	Certification:	4 ☐ Homicide building, etc. (Specify) City or Town, State)
	hours uners		29a. Certifier (Check only (C
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	one) and manner stated.
	viii Cor	4	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	1		Paul A, DEVORE MD 4723 QUEENSburg Rd HYGTSV; HE MD 20151
	4		Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A NELOPE MA GORDEN CHURCH PARTSU; HE MA 2015/
		l l	The state of the s

State Registrar 31. Date filed (Month, Day, Year) AUG 0 1 2008

82. Registrar's Signature

1 - For State Registrar 1. Decedent's

31. Date filed (Month, Day, Year)

Director

Be Completed by Funeral

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Examiner

Medical Certification: To Be Completed by Physician/Medical

Physician

/Medical

Examiner

Funeral

Director

Physician

/Medical

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran.

For State Registrar			Ce	rtifica				ntal Hygie Rea	. No. 🥎 1	0.0.0	0170
. Decedent's Name (First, Middle, La	ast)						2.	Date of Death		U U B	3. Time of Death
Harris Benesch F	ine							Month 7-28-200	Day 08	Year	4:20 AM
a. Facility Name (If not institution, gi	ive street and nu	mber)		4b. City	, Town, or	Location of Dea	ıth		4c. Cou	nty of Death	
Heritage Center	Nursing	Home		Dı	ında1	k			3	Baltim	ore
	Sex 11∭ M 2 □ F	7. Age (In yrs.) If Unde	r 1 Year Days	If Under 24 Hrs Hours Min	s. 8.	Date of Birth (Month, Day, Y 4-08-19	e <u>ar)</u>	9. Birth	place (State or Foreign
218-26-6904	ILLUM ZLIF	77	Yrs.					4-08-19	31		MD
sual Residence of Decedent Da. State 10b. County		10c. Ci	ty, Town or L	ocation							10d. Inside City Limits
											1 ☐ Yes 2 ☑ No
MD Howard De. Street and Number		L L	licott		y ip Code			100	Citizen	of What Cou	intry?
8573 Falls Run F	od IIni+	D			1043			1.09		.S.A.	,
1. Marital Status		edent Ever in U	IS 13			lispanic Origin? (Specif	v Yes or No-	_	Race - Amer	ican Indian
1 ☐ Never Married 2 ☑ Married	Armed Fo	orces?		If Yes, spe	ecify Cuba	in, Mexican, Pue	rto Ric	an, etc.)		Black, White,	etc.
3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ve		1 ☐ Yes	2 No	Specify:			Spe	ecify: wh:	rce
15. Decedent's E	Education			edent's Us			17:	16	b. Kind o	f Business/Ir	ndustry
(Specify only highest gi	rade completed) College (1	1-4or 5+)	(Give	e kind of w DO NOT (ork done d use retired	during most of wo d)	orking				
Listing (0-12)	2		Truc	ck Dr	iver				Trans	sporta	ition
7. Father's Name (First, Middle, Las	st)							irst, Middle, Ma	iden Surr	name)	
Albert Fine						Helen	Coo	per			
9a. Informant's Name/Relationship	(Type. Print)			-	,	and Number or F		,	,	, ,	r
Mrs. Patricia Fi	ine / wi	fe	8573	B Fall	ls Ru	ın Rd.,	Uni	t D; E1	lico	tt Cit	y, MD 2104
3a. Part1. Enter the disease, or cor shock, or heart failure. List only mediate Cause (Final isease or condition ssulting in death)	y one cause on a	caused the dealeach line.	th. Do not er				ac or re	espiratory arres		rnie,	MD 21061 Approximate Interval Between Conset and Death
requentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury ause (Disease or injury hat initiated events esulting in death) Last	b. Due to	(or as a consec	quence of):								
F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	1 🔲 Live	tcome of pregn birth 2 ☐ Fet Inant at time of nown	al death 3	☐ Ectopic ☐ Other (s		у			23d.	Date of deli	very Day Y ear
rart II. Other significant conditions	contributing to d	eath but not re	sulting in the	underlying	cause giv	en in Part I.	.		cco use c		the cause of death?
					<u> </u>		-	24a. Was an autopsy performe 1 □ Yes 2		prior to c death?	opsy findings available ompletion of cause of
5. Was case referred to medical examiner?							eath (C	Check only one)			
1 Yes 2 No	Hospital: 1 🗆	Inpatient 2	 		Oth Oth	er: 4 Nursing	Home	5 ☐ Residen	ce 6 🗆	Other (Spec	eify)
7. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred					curred					
2 ☐ Accident investigation	on	. ,/		M		Yes 2 □ No					
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place	of Injury - At h	nome, farm, s	treet, facto	ry, office		28f	Location (Stre City or Town,	et and Nu	ımber or Ru	ral Route Number,
		a, (opou	.,					2, 0. 10 111, 1	/		
29a. Certifier (Check only one) 1 Certifying F	aminer: On the t	e best of my kn pasis of examin nner stated.	owledge, dea	ath occurre investigation	d at the ti	me, date and pla opinion, death oc	ce, and	d due to the cau at the time, date	use(s) and e and pla	d manner as ce, and due	stated. to the cause(s)

State Registrar

amend item 3 per doc 882 8-1-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year MARION 20 2008 TULY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ARE HOME WOOD MI SALTEMOR UTURE Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** 1 1 M 2 □ F Year) Months Days Hours O 36-20-374 Usual Residence of Decedent 80 Director MA45 1928 5 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director BALTI MORB MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with LEWING ANY AUG 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No Funeral 21218 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK If Yes, Give Year or Dates: Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) STEEL Campan Berh STEGL GLAGE NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DOCIA WILLIAM ပ BRADLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BACTIMON MO 21218 LLIAN KENWEDAY 14 UCE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit, Pages 1 Department of I Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MEM PK July 26 2008 KANDLTOWN AND 21. Signature of Europe Service Licensee 22. Name and Address of Facility BITTS FUNERAL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** einer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dulls to (or as a none-quence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. the 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy performed **Division of Vital** 2 No 1 □ Yes 2 [] NO 1 🗀 Yes or Attending Physician: 25. Was case referred to predical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Designation Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 🗆 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0062638 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ungt 1600 20 31. Date filed (Month, Day, Year) egistrar's Signature State AUG 0 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:05 PM July 24 2008 Salim George Fattal /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville 1 Year | If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Yrs 127-28-1325 Director September 26, 1930 Syria Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and Mental Hygiene. Is marked other then "natural", or items 23a or 28a-f show raumatic event, I've Medical Exeminar mant be notified at 1 ☐ Yes 2 1 No Directo Gaithersburg 10f. Zip Code Marvland Montgomery 10e. Street and Number 10g. Citizen of What Country? 11730 Clopper Road 20878 by Funeral <u>United States</u> 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Civil Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Georges Fattal <u>Araxy Ipekian</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georges L. Fattal/ Son 853 Red Rock Court, Suwanee, Georgia 30024 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State August 2, 4 ☐ Donation 5 ☐ Other (Specify) St, Mary's Cemetery 12008 Rockville, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Sulles M01532 BOO West Montgomery Avenue, Rockville, Maryland 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac pulmonary Arrest Due to (or as a consequence of): disease or condition resulting in death) 10 Minutes Sepsis
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 仑 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 1 ☐Yes 2 ☑ No 21 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

filed within 72 hours after (Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othr eny injury or other traumatic commen

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed physician and s the burial-trans use as P.O. I signed by the e of Vital Records, cate has bage 2 s certificate

director,

or Attending Physician: this After th death. Director: ithin 24 hours af o the Funeral Di o the Funeral Di ompletely filled in Hospital

Division

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	200)
ī	8	s

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

D0065505

9901 medical center Dr. Rockville, MD

m.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHENG

QIUFANG

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Antonio Fernandez 2008 3:25 P 26, July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 20, Birthplace (State or Foreign Country) Funeral 1 X M 2 □ F Months Days Hours Min. 92 1916 Spain Director 083-16-6993 Usual Residence of Decedent 10c. City, Town or Location show 10a, State 10b. County 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be nutilied at Director 1 ☐ Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6305 Swords Way 20817 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 K]Yes 2 □ No 1941 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any finury or other traumatic event, the Medical Examinary Injury or other traumatic event, the Medical Examinative. 1 Never Married 2 Married 1941- 1945 If Yes, Give Year or Dates: 1∭Yes 2∐No ≥ Specify: Spanish White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Stationary Engineer Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Manuela Fernandez Antonio Rama ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Fernandez/Daughter 6305 Swords Way, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 29, 20c. Location - City or Town, State 1 ☐ Burial 2 II Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 2008 Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Rockville, Inc. Wilken -4. M01173 300 W. Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arms t, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Subdural Hematomas m Due to (or as a consequence of): Intracranial Bleek Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sepsis Due to (or as a consequence of): Physician/Medical Diabetes Mellitus IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Falls Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown peen Protein Calorie Malnutrition 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe Hypertension 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🕅 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1[XYes 2 □ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Trip and Fall 5 Pending investigation 1 ☐ Natural July 17, 2008 UNK 1 ☐ Yes 2 🎇 No 2 X Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 20850 filled in by determined 4 Homicide Assisted Living 8 Baltimore Rd., Rockville, MD 1\(\frac{\text{M}}{2}\) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2\(\text{M}\) Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

/Medical Examiner The law requires that the death certificate be executed sician and burial-trans Box 68760, attending physician for use as the buria signed by the a P.O. of Vital Records, certificate has or Attending Physician: After this Division s after deau. ral Director: Aftr To the Hospital o within 24 hours af To the Funeral Di

death

Baltimore, Maryland 21215-0036

State Registrar

29c. License number MD D55054 29d. Date signed (Month, Day, Year) July 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Attan Kasid, M.D. 604 S. Frederick Avenue, #409, Gaithersburg, Maryland 20877

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



and manner stated.

Brian Lloyd Gordon Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 24795 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 27, 2008 1330 hrs Brian Lloyd Gordon Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Washington Brownsville Pass Brownsville 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or ForeignBaltimore, 1f Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Social Security Number 6. Sex **Funeral** 218-72-1188 Months Days Hours Min. 10/26/1958 Director Count Maryland Yrs. 1X M 2 49 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1XX Yes 2 No Baltimore 28a-f show narked other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at once. Direct 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? United States 3 Tamworth Road 21210 America Funeral 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces 1XX Never Married 2 Married white f Yes, Give Yee Divorced Yes 2XX No specify. Specify: Widowed 27 is marked other than "natural", ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages I and 2 should be filed within 72 hou. Department of Health and Mental Hygiene. Important: If item 27 is marked a filed within you with the permit of the pe Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Food Service 4 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bernard Lloyd Gordon Be Elizabeth M. Kandra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Robert Dubeau/ partner Baltimore, Maryland 21210 3 Tamworth Road 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place)
Evans Funeral
Chapel- Bel Air July 30, 2008 Burial 2XX Cremation 3 Removal from State Forest Hill, Maryland Donation 5 Other Specify: Eaceful Alternatives Funeral & Cremation Ctr., P. A 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Shotgun Wound of Head/Neck Immediate Cause (Final disease ⁻xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit executed Physician/Medical attending physician or use as the burial -UNPENDED AMENDED The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown q Unknown the 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 Nο or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital director. Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene this 1 V Yes ပ္ funeral 28a. Date of Injury (Month, Day,Year) FOUND: 28d. Describe how injury occurred 28c. Injury at Work? After 27. Manner of Death 28b. Time of Injury Certification: Subject shot self 1 FOUND Natural Yes 2 V No hours after death.

uneral Director:

ly filled in by the fi death. Pending Jul 27, 2008 1315 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be or Town, State) Brownsville Pass, Brownsville, MD within 24 hours a To the Funeral I determined (Specify) Park/Recreation Area Hospital 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 28, 2008 O.C.M.E.

• 15

State 31. Date filed (Month, Day, Year)
Registrar AUG 0 1 2008

Carol Allan, MD

82. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:26 AM DONALD **GROSS** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARFORD BEL AIR UPPER CHESAPEAKE MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 1√2 M 2□F 72 188-28-7142 2/25/1936 PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director **JOPPA** MD HARFORD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21085 **USA** 811 FOXWELL ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X1 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2X No Specify. WHITE \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT CHEMICAL ENGINEER 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (SAMUEL **GROSS** ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLYN GROSS / WIFE 811 FOXWELL ROAD JOPPA, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State OHEB SHALOM MEM. PARK 8/4/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 21. Signature Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Henor Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autonsy performe In cu 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Propatient 2 ER/Outpatient 3□ DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a Certifier (Check only one) and manner stated.

Hospital or Attending Physician: 24 hours after death. within 24 hours after death To the Funeral Director:

Funeral

Director

r 28a-f show notified at

r than "natural", or Items 23a or the Medical Examiner must be

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permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr.

Physician

/Medical

Examiner

death with the Maryland

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ress of per up who

Registrar

DHMH 17 Rev 1/2001

empleted cause of death (Item 23a) (Type, Print) poss 32 Regis rar's Signature

29c. License number

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500 upper Cherapeake

29d. Date signed (Month, Day, Year)

30, 2008

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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PATUKENT PARKWAY

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2008

aruma. A 40 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23a, 25, 27, 28a-f per me 8882 08/01/08dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 01 2008 Month Rosa Lee Hasty Physician 11:20 PM Tune /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Agnes Hospita N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 229.30.5018 1 □ M 2 💢 F Director 20 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits "natural", or Items 23a or 28a-f shov Baltimore Baltimore MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rolling Road 21208 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Black 3XWidowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur: any Injury or other traumatic event, <u>the Medical E</u> 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (Q-12) College (1-4or 5+) Seamstress 10th, grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Millie Davis nances ဨ awson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4-Rolling Daughter Road Pikesville MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 □ Removal from State Arbutus Memorial Park 06/07/08 Baltimore, MO 21. Signature of Funeral Service License 22. Name and Address of Facility Vaughn C Greene Fundal SVO Vausha 8728 Liberty Road Randall Stown Mb 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerula Dolens **Physician** nleamasia disease or condition resulting in death) /Medical Examiner vena cava venous thrombisis CATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed Hematoma burial-tran Due to (or as a consequence of) physician Physician/Medical CER the as attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.O. the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform certificate Vital 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 XYes -25X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA Division 6r 27. Manner of Death 28a. Date of Injury (Month, Day 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Year 1 Natural 2 Accident 5 Pending investigation Unknown **Unknown**^M 1 ☐ Yes 2 No Multiple falls. Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after Unknown Unknown within 24 hours a Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 de lastro June 01, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Avenue. Baltimore, Maryland 21229 Gerard De Castro 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 5 2008 Registrar

			Please Amend #27 & 28a-f, - State Registrar	Type or Prit PerME G881 State of Ma AMEND TIP	it in E arylan M#19a	Black I 25/08 id / De .per. H	ndelib partme	ent of F	Ensure	All Copie Mental H	s Are	Legible	e. g 2	1.799
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Î	Funeral Director		5. Social Security Number 6. S 0 8 168-3652		dica e (In yrs. 41	last birthda Yrs	(ay) If Und	er 1 Year	If Under 24 Hrs Hours Min		Birth Day, Year) 2 , 19 6		Birthplace (S Country) W York	State or Foreign
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036	rs a	þ	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 ▼ 1 If Yes, Give Year or Dates:		.S. 1		edent of Hoecify Cuba 2 X No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or I rto Rican, etc.)		14. Race - A	American Indi /hite, etc.	ian,
ر Baltimore, Maryland 21215-0036	within 72 ho ene. than "natu	Completed	15. Decedent's E (Specify only highest gr.	ducation ade completed) College (1-4or 5	+)	16a. De (Gi life Honen	cedent's Us ive kind of w e. DO NOT	sual Occup vork done use retired	ation during most of wo d)	orking		Kind of Business/Industry		
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Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Lice	hsee Z		E	tans F	meral	ss of Facility Channel & Ve, Forest	Cremetic Hill, M	n Serv arylan	d 21050	al Air	
Har M	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or comshook, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	plications that caused one cause on each line. a. Acet aw Due to (or as b. Due to (or as	a conseq	uence of):			with (Complic	ation	V- L	Interv	eximate all Between that and Death
11.00a.	or cis	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a conseq	uence of):			CERTIFICAT	TION APPROVED	BA WEDI			
SO. Box	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	al death	3 □ Ectopic 5 □ Other (у			23d. Date of Month	delivery Day	Year
#33	equires tha sen signed ould be det	ted by P	Part II. Other significant conditions	endency	ut not res	ulting in the	underlying	cause giv	en in Part I.			use contribut		se of death?
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of V	g Physicl er this ce ieral direc		examiner? 1 ☐ es 2 ☐ No 27. Manner of Death	Hospital: 1 Impatie	ry	28b. Time		DOA Oth	er: 4 🗆 Nursing	Home 5 Re	sidence		Specify)	
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	(5)		30. Name and address of person who	completed cause of d	_		C1	i	40316	more	710	•	7	2008
	Stat Registra	~	Stephen Liang, 1 31. Date filed (Month, Day, Year) JUL 2 5 200	192 Registre	ar's Signa	ature	- ST	ret,	Salt	more	, ML	712	_0(

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Loretta Harding	1	State of Maryland / Department of Health 1- For State Certificate of Death	(2008 24801			
Physicia		1. Decedent's Name (First, Middle,Last)	Reg. No. 2. Date of Death Month Day Ye	3. Time of Death			
Medical Examir		Lorella Harding	July 23, 2008	1119 nrs			
("		4a. Facility Name (if not institution, give street and number) 2004 Elsworth Street Baltimo		NA			
Funeral Director	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months	1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY Days Hours Min. Feb. 10, 1949	Y) 9. Birthplace (State or Foreign Country)			
Billeditor	_ L	217-52-6224 1 M 2 F 59 Yrs. World's Usual Residence of Decedent	1 10110,1171				
nd Show any nce,		10a. State 10b. County 10c. City, Town or Location	Baltimore	10d. Insude City Limits 1 Yes 2 No			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 2004 Gloworth St. 10f. Zip C		What Country?			
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after dez	by Fu	3 Widowed 4 Divorced or Divorced or Dates:	No specify: Specify.	Black			
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5-0036 led within 72 Hygiene. other than the Medical	Completed	Dis	abled	NIA			
21215-0036 uld be filed within 77 Mental Hygiene. marked other than	Be Cor	17. Father's Name (First, Middle,, Last) Woodrow Harding	18.Mother's Name (First, Middle, Maiden Surnam	ne)			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If tiem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	ToE	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address 1908 N.					
ore, M es 1 and 2 of Health If item 2	ł	20a. Method of Disposition 20b. Place of Disposition (Nam.	e of cemetery, Date 20c. Location	n - City or Town, State			
Baltimore, Permit. Pages 1 a Department of He Important: If ite		4 Ponation 5 Other Specify Trinity Cemer	ens 7/30/08 Baltin	nore, Maryland			
Baltimo permit. Pag Department Important:		21. Signature of Funeral/Service Licensee 22. Name and A 35/2 F	addless of Facility Parker Funeral Hon- Frederick Ave, Baltimore	Mondard and			
Physician	\neg	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.		Between Onset and			
/Medical / Txaminer		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascul	ar Disease	Death			
		Sequentially list conditions, b	· · · · · · · · · · · · · · · · · · ·				
7)	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated					
ransit		events resulting in death) Last Due to (or as a consequence of): d.					
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Box 6 e death cer the attendi	- 73 I	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Spec	fy)				
ed by	by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying		ntribute to the cause of death?			
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Division To the Hospital or Attendit within 24 hours after death To the Funeral Director; A completely filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory,	office building, etc. 28f. Location (Street and Nur or Town, State)	mber or Rural Route Number, City			
Dispital bours a meral I		4 Homicide determined (Specify)					
thin 24 the Fr of the Fr	Medical	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	opinion, death occurred at the time, date and place, an	d due to the cause(s)			
7. ¥ £ 8.	Me			igned (Month, Day, Year)			
		Lamely Pruthass, no	O.C.M.E. July 23,	2008			
6			Street, Baltimore, MD 21201				
.S Regis	tate						
Regis	util	LIVU TO STORE STATE OF					

Physician /Medical Examiner death certificate be executed for use as the burial-tran and P.O. Box 68760, physician attending ned by the a Records, signe I be d peen page 2 has certificate or Vital Physician: director. this After thi or Attending Division death. within 24 hours after death

To the Funeral Director: completely filled in by the f

Funeral

Director

s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1
Department of H.
Important: If Iter
any Injury or ott

Medical Certification: To 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

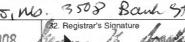
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State Registrar

31. Date filed (Month, Day, Year)

1

29b. Signature and title of certifie



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wite, Ms. 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

To the Hospital

08-05796 Robert Haines

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

bert Haines		- For State	e of Maryland / De _l C	oartment of ertificate of		d Mental H		No. 20	00 21.00	
Physicia		Registrar 1. Decedent's Name (First, Middle,L					Reg. 2. Date of Death		3. Time of Death	
edical Examin		Robert A	ltherton t	taines	s Jr	عدا لاست	July 29, 200	ay Year 8	1137 hrs	
		4a. Facility Name (if not institution, ç 2111 Glencove Road	give street and number)	2	b. City, Town, or Darlington	Location of Death		4c. County of Dea Harford	th	
Funeral		5. Social Security Number 6.	Sex 7. Age (In yr:	s. last birthday)	If Under 1 Year Months Day				orthplace (State or Foreign country)	
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of the the	Funeral Director	211 Glenco 11. Marital Status	12. Was Decedent Ever in	US 13 Wa	s Decedent of His	spanic Origin? (S	pecify Yes or No-	14. Race - Am	otates erican Indian, Black.	
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more, MD 21215-0036 Pages 1 and 2 should be filed within 72 tent of Health and Mental Hygiene unt: If item 27 is marked other than 'n		Grace D. Ho	aines-wife	2 2111	Glenc	oue Y	ad De	arlingto	nmb 21034	
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alt mit por ury	Ī	21. Signature of Funeral Service Lie		22. N	Name and Addres	s of Facility		remation	Services	
	4	Stage Xr	martin	13	Demo	port Dr	ive. Fo	rest Itill	mb 21050	
Physician /Medical		23a. Part I. Enter the disease, or co failure. List only one cause on	each line.		ne mode ot dying	, such as cardiac	or respiratory arres	t, snock, or neart	Approximate Interval Between Onset and Death	
⁻xaminer	ĺ	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence						Death	
/		Sequentially list conditions,	b.							
	ē	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	e of):						
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):						
ecuted and transit			d							
0, e be exe sician a	edical	UNPENDED	AMENDED							
760, icate by g physic the bur	§	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of p					23d. Date of deliv		
certifications as	ia.	past 12 months?	1 Live birth Pregnant at time o	f dooth	etal death 3 ther (Specify)	Ectopic pregn	ancy	Month	Day Year	
Box 6876 ne death certificate the attending phy ned for use as the b	Physician/M	1 Yes 2 No 9 Unkno	9 Unknown		() () () () () () () () () ()					
ires that the signed by 1 be detache	by PI	Part II. Other significant condition	ns contributing to death but n	ot resulting in the t	underlying cause	given in Part I.			to the cause of death?	
S, P nires th									robably 4 Unknown	
ords w requi	plet						24a. Was an autopsy	prior t	autopsy findings available o completion of cause of	
Record The land	Completed						perform 1 Y Yes 2		param,	
Vital Records, ysician: The law requil his certificate has been director, page 2 should	Bec	25. Was case referred to medical examiner?			26.Plac	e of Death (Check	only one)			
hysic r this	2	1 ✓ Yes 2 No	Hospital: 1 Inpatient 2					esidence 6 🗸 Ot	her: Scene	
Division of Vital Records, 111 or Attending Physician: The law require cafter death. 1 Director: After this certificate has been side in by the funeral director, page 2 should be a feet of the page 2.	ertification:	27. Manner of Death 1 Natural 5 Pendin	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of FOUND:		ury at Work? Yes 2 ✔ No	Subject shot	w injury occurred self		
'SiG	licat	2 Accident Investig 3 Suicide 6 Could n	28e Place of Injury - 4	1133 hrs At home, farm, stre	et, factory, office	building, etc.			Rural Route Number, City	
Division Spital or Attend hours after death hours after death uneral Director: y fill d in by the	erti	4 Homicide determ		anch			or Town, Sta 2111 Glencove	_{ite)} Road, Darlingtor	, MD	
Livision of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funer-1 Director: After this certificate has been signed by the attending physician and completely fill d in by the funeral director, page 2 should be detached for use as the burial - trans	cal C	29a. Certifier 1 Certifying Physone)	sician: To the best of my know iner:On the basis of examination	viedge, death occu	rred at the time, o	date and place, an	d due to the cause	(s) and manner as s	tated.	
To t with To t	Medical	29b. Signature and title of certifier	and manner stated.					29d. Date signed (i		
617		0.111	MI	29c. License number O.C.M.E.					,	
		30. Name and address of person w	e completed cause of death (Item 23a)			July 30, 2008			
4+1	12	Russell Alexander MD.	Assistant Medical Ex		l Penn Street	t, Baltimore, N	/ID 21201		N.	
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	F. 1			· · · · ·	·	
Regist	الفادا	HUU V I ZU	OU ACTIONS A	STATE OF THE STATE	15.0			OCIVIE		

				e Type or Print in E State of Marylan				•	•	
			1 - State Registrar	<u> </u>		rtificate of		Reg. N	2000	24803
	Physici /Medic		1. Decedent's Name (First, Middle, L Zena Rochelle	,				2. Date of Death Month	ay Year	3. Time of Death 3 5 . 45 PM
7	Examin	er	4a. Facility Name (If not institution, g.			4b. City, Town, o	r Location of Death		c. County of Dea	
	Funeral		Social Security Number 6.	Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs.	9 Date of Birth	0.0:-	Alamina (CA-A
	Director		Usual Residence of Decedent	1LM 2LF 50	Yrs.			Month, Day, Yea July 20,	1958 Ма	aryland
o Maria	3a-f show	Director	10a. State MD 10b. County Bal	timore 10c. Cit	y, Town or Lo		dalk			10d. Inside City Limits 1 □ Yes 2 No
đ địn	23a or 24	al Dire	10e. Street and Number 889 Jaydee A	venue		10f. Zip Code	21222	10g. C	itizen of What Co USA	*
.0036	ous aret death with the maryfal ral", or items 23a or 28a-f show Evar item must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 🐹 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cub 1 □Yes 2 🛣 No	Hispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B	e, etc.
န် ငှဲ	ar ar	Completed	15. Decedent's E (Specify only highest g	rade completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation during most of workir d)	16b.	Kind of Business	Industry
	ygiene jer tha	Com	Flementary/Secondary (0-12) 12th Grade	College (1-4or 5+)		_	nier		WalMa	ırt
	eve eve	To Be	17. Father's Name (First, Middle, Las Hubert Sturda					(First, Middle, Maide Estelle		n
Ξ̈́	iges I and 2 should be it of Health and Menta if Item 27 is marked or other traumatic ev		19a. Informant's Name/Relationship Reginald D. Ho	(Type Print) Husband auser, Sr.	19b. Mailii 889 .	ng Address (Street Jaydee 2	and Number or Rura Avenue Di	I Route Number, City	or Town, State, . Marylar	Zip Code) ad 21222
	nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐ Removal from State	Place of Disponentery, crea	osition (Name of matory or other place	ce) D	ate 20c.	Location - City or	Town, State
	: 돈 뜬 글	17	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice				etery 8/2		ltimore	e, MD eral Home
ň	Depar Impor any ir	1 4	· Culler	Carus	4:	210 Bela	air Road	Baltimo	re, MD	21206
P	hysician ˈ	8 5	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	nplications that caused the death , one cause on each line.	h. Do not ent			r respiratory arrest,		Approximate Interval Between Onset and Death
1	/Medical xaminer		disease or condition resulting in death)	Due to (or as a consequ	uence of):	Bleed	aing			
		ler	Sequentially list conditions, if any, leading to included cause. Enter Underlying Cause (Disease or injury	b. Esophage	uence of):	Cance				
A Court of the Cou	and -transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C						
۾ م	icia	g		Due to (or as a consequent	uence or):					
A 500	ling phy e as th	Medi	IF FEMALE:							
ecords, P.O. Box 687	been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	Ideath 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	y -		23d. Date of de Month	livery Day Year
S, F.	igned b	by Pr	Part II. Other significant conditions	contributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
	been s	eted							<u>, </u>	robably 4 Unknown
r	icate has	Completed						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
VIC	s certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 □	EB/Outpatier	ot 3 🗆 DOA Oth	er: 4 Nursing Hop	(Check only one) ne 5 ☐ Residence	6 DOthor (Co-	
VISION OF	th. : After thi e funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	f 28c. Injur Wor		8d. Describe how inju		Спу)
DIVISION OF VITAL To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not l 4 Homicide determined		ome, farm, str y)	eet, factory, office	2	8f. Location (Street a City or Town, Sta	nd Number or Ri te)	ural Route Number,
ie Hospi	in 24 hou he Funer pletely fill	Medical	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	thysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the ti vestigation, in my o	me, date and place, a opinion, death occurre	and due to the cause ed at the time, date a	s) and manner and place, and due	s stated. to the cause(s)
Tot	To the	Σ	29b. Signature and title of certifier	DRISAR	NATE	29c. Licens	e number	29d. D	ate signed (Mont	h, Day, Year)
	3		30. Name and address of person who	completed cause of death (Item	1 23a) (Type,	Print)			1/40	
	Sta	te	31. Date filed (Month, Day, Year)	#2. Registrar's Signa	ture	•	ale Drive	2 Baltima	ie, mo	21237
DULT	Registr	-6	AUG 0 1 200	8 Alexan S.	Anen	K)				
וואורור	17 Rev 1/20	JUI			50					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 20:22M Juan Antonio Hunter JUL 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 4c. County of Death Examiner N/A Union Memorial Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours **№** М 2 🗆 F 214-82-9456 1960 New York Director 28, 47 Sept. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show Baltimore N/A1XXYes 2 ☐ No Director Maryland 10f. Zip Code 21215 10e. Street and Number 10g. Citizen of What Country? 3618 Cottage Avenue USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ★Yes 2 □ No 1978 -11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: Completed by 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 1982 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Steel and Wire Co. permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rany njury or other traumatic event, the Mad once. Elementary/Secondary (0-12) College (1-4or 5+) Fork Lift Operator 12th grade 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Nelson 17. Father's Name (First, Middle, Last) Be Reno Hunter 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2r 3618 Cottage Avenue Baltimore, Md 21215 19a. Informant's Name/Relationship (Type. Print) Margaret Hunter-Hance/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 8/1^{Date} 8 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) owings Mills, Maryland Garrison Forest Vet. Cem. 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, effect, or heart failure. List only one cause on each line. Immediate Cause (Mal Hyperkalemic **Physician** 8 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed burial-tra resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 2 **N**o 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this ours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier AU4176435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALAKRIS M.D. UNION MEMORIAL HOSPITAL, MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 11:26p ™ 26 2008 Richard M. Harris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Blue Point N/H If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 4-23-1942 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Min. 1 M 2□ F Months Hours Director ٧A 66 579-58-2490 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 □ Yes 2 □ No Director MD N/A Baltimore 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? filed within 72 hours after death with Hygiene. Fourth Avenue 21244 U S Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, GiveX Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 ☐ Married 1 □Yes 2/□No Specify: \$ Black 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) llth grade Disabled N/A <u>Disabled</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental 8 Mary Elizabeth Lewis Lonnie Richard Harris ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 st of Health a Hem 27 it 2114 Fourth Avenue Balto, MD 21244 Lonnie Harris-Nephew 20c. Location - City or Town, State Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If It any Injury or or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7-31 -2008 Balto, MD Greenmount Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East North Avenue Balto, MD21202 an 1101_E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (= E RENAL **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-tran and Due to (or as a consequence of): physician a Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Day Year signed by the a d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1 ☐ Yes 25 Hospital or Attending Physician: '24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I npletely filled

Box 68760. P.O. I Division of Vital Records,

Saltimore, Maryland 21215-0036

To the within ?

the the

> State Registrar

Medical

29b. Signature and title of certifier

29a, Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:30 Ам 2008 30 July Mary Frances Hayton /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 1900 Grove Manor Drive, Apt. # 100 Essex 9. Birthplace (State or Foreign Country) New Jersey If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2000 06/26/1912 139-09-9694 96 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm Medical Examination to motified at 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 21221 U.S.A. 1900 Grove Manor Drive, Apt. #100 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department Store Manager 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk. Dominico Gerardo ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar 822 Thimbleberry Road, Baltimore, Maryland 21220 permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tri Sharon McCleaf (Granddaughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/01/2008 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Mcensee 23a. Part 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 21221 Approximate Interval Between Onset and Death Immedi e Cause (Final diseas r condition resulting in death) Heart Failure Shrs **Physician** Congestive /Medical Due to (or as a consequence of): Examiner pertensive Athersdenthe Contiduasation Disease lours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and accompletely filed in by the funeral director, page 2 should be detached for use as the burial-transity. Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 → 10 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mannes of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🕶 certifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D39660 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Point Rd. Baltimore, MD Robert-Wort 75000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 1 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene T = For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** July 30,2008 10:00 A M Ralph Emerson Horstman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7200 Hughes Avenue Sparrows Point Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/30/1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours Days 1⊠M 2□ F Months 217-22-6586 83 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Event incr must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Funeral Director Maryland Baltimore Sparrows Point 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21219 7200 Hughes Avenue U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Technician Welding Supplies 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Anna Fuenfgeld Robert Emory Horstman မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Horstman (Wife) 7200 Hughes Avenue, Baltimore, Maryland 21219 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition txxBurial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gard.08/02/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Bruzdzinski Funeral Home, P.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 Standard of Funeral Survey Licenside 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 4 cm dis ase or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner riany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): burial Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No o 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★ Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မှ 1 Inpatient To the Hospital or Attending Phys Within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 Tyes 2 □ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of o 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tan us mi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** 4:30 John Michael PM Horney 30. July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore 24 Joggins Court Middle River 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/15/1937 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 🖾 M 2 🗆 F 70 Maryland Director 217-34-4211 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Baltimore 1XXXes 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 U.S.A. 324 South Lehigh Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: ò Specify. unk. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. Telecommunications Technician 6 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Sloman John W. Horney Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau
once. 324 South Lehigh Street, Baltimore, Maryland 21224 June Marie Horney (Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/02/2008 Gardens of Faith Baltimore, Maryland 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signatur J.F. Haral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme is te Cause (Final disease or condition resulting in death) **Physician** 2 MONT41 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and Due to (or as a consequence of): burialphysician the burial Box 68760, Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵. s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 MYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performe The certificate 1 □Yes 2X No 2 5 No Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Nother} \) (Specify) Residence examiner? Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 10 41 30. Name and address of person who completed cause death (Item 23a) (Type, Print) J4BVM2 VAIRI MICHAEL 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

			For	State of Ma	aryland / D	epartment of	Health and M		-	21,200
			Stata Registrar		(Certificate of	Death		, No. U U O	24003
	Physic /Medi		1. Decedent's Name (First, Middle, Last	V	HAR	PH		2. Date of Death Month	Day Year	3. Time of Death 8 10.00 M
	Exami		4a. Facility Name (If not institution, give			C 1.1.	or Location of Death	r.	4c. County of Deat	
	Funeral Director		5. Social Security Number 6. Se 220-24-2337	00 C C C C 7. Age	o (In yrs. last birth	Months Davs	If Under 24 Hrs.	6. Date of Birth (Month, Day, Y	ear/	hplace (State of Foreign untry)
	Maryland -1 show	tor	Usual Residence of Decedent 10a. State 10b. County 10b.WA	-RD	10c. City, Town	or Location Vum Bin	9			10d. Inside City Limits 1 Yes 2 ☐ No
	death with the Maryland rms 23a or 28a-f show rmust be notified at	I Director	10e. Street and Number	nountain	Circle	10f. Zip Code	2104	4 100	g. Citizen of What Co	ountry?
	of teams 2	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent E Armed Forces? 1 X Yes 2 N	Ever in U.S.	13. Was Decedent of If Yes, specify Cut		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	rican Indian, e, etc.
	1215-0036 within 72 hours atter ene. than "natural; or ite tra Madical Exerting	by	3 Widowed 4 Divorced		16a. D	1 ☐ Yes 2 🗷 No	nation	16	Specify: 6	Industry
	id 21215-0036 filed within 72 hours aft Hygiene, other then "natural", or ent, the Madical Exern	Completed	(Specify only highest grad	College (1-4or 5	+1	Give kind of work done ife. DO NOT use retire	Let	ing	USA	
	Maryland 21215-0036 Id 2 should be filed within 72 hours after dea th and Mental Hygiene. It is marked othar then "natural", or items traumatic event, the Madical Exerpterm	To Be	17. Father's Name (First, Middle, Last) Solomon HAA	PJR			18. Mother's Name	e (First, Middle, Ma	LLEX	
	Ma od 2 s lith ar 127 is		19a Informant's Name/Relationship (T	ype, Print)	le 10		enmount	an ar	Columb	16 MO
	Baltimore, permit. Pages 1 at Department of Heal Important: if item any injury or otha once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,		ArLING	Disposition (Name of crematory or other place)	ace)	Date 20	Oc. Location - Gity or	Town, State
AR	Balt permit. Depart Import any inj		21: Signature of Funeral Service Licent	vell 8	7	22. Name and Addr	ess of Facility LL	Divell. Jessy	FUNER	or stone
Z	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused ne cause on each lin a	the death. Do no	t enter the mode of dy	ing, such as cardiac	or respiratory arris	t,	Approximate Interval Between Onset and Death
	/Medical Examiner			b	ty por	enno				5 year
MON	760, K	cai Examiner	Sequentially list conditions, it any testing to the solid to the solid cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequence of	tus lela	٨			3 month
0	0 0			d						
201	BC death	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify) □	су		23d. Date of del Month	ivery Day Year
	I Records, P.O The law requires that the ate has been signed by the	by	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in t	he underlying cause gi	ven in Part I.		cco use contribute to	the cause of death?
	Division of Vital Records, tor Attending Physician: The law requires taller death. Diractor: After this certificate has been signed in by the funeral director, page 2 should be	Completed						24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
	Vital F	BeC	25. Was case referred to medical examiner?					(Check only one)	11165	2 140
	on of Vital Reding Physician: The In. After this certificate har funeral director, page	은	1 Yes 2 No		nt 2 ER/Outp	atient 3 DOA		me 5 Residence 28d. Describe how	ce 6 Other (Specialized	cify)
	ion (inding Path.	ation	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year) Inji	ury Wo	ork?]Yes 2□No	200. 2000.00 11014	inquiry occurred	
	Division To the Hospital or Attending Within 24 hours after death. To the Funaral Director: After completely filled in by the funa	Certification;	3 🗍 Suicide 6 🗎 Could not be determined	28e. Place of Injubulding, etc.	iry - At home, farn :. (Specify)	n, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	he Hospi in 24 hour ha Funar pletely fill	edical	29a. Certifier Certifying Phy (Check only one)	sician: To the best of iner: On the basis of and manner sta	examination and/	death occurred at the tor investigation, in my	ime, date and place, opinion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To t withi To ti	Σ	29b. Signature and title of certifier	VI Sid	1 Att		se number		Date signed (Month	
	le		30. Name and address of person who c	ompleted cause of	eath (Item 23a) (T		PKWY	GREGE	UBELT	MD 770
	Sta Regist		31. Date filed (Month, Day, Year) AUG 0 1 2	32. Registra	r's Signature	Sparke	,			

Reg. No.

Physician
/Medical
Examiner

Funeral

Director 28a-f show other traumatic event, the Medical Examiner must be notified at 23a or 2 death with or items Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Iter Department of Heal Important: If item 2 any Injury or other once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burlal-transit Box 68760, P.O. I ed by the a detached f Records, certificate Division of Vital After I Director: d in by the f within 24 hours a

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year GRACE E. HYLE JULY 10:52M 3121. 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 1 □ F 89 212-10-9457 10/7/1918 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA Funeral 8666 OAK ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: WHITE <u></u> 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SINAI HOSPITAL REGISTERED NURSE 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM E. GUY GLADYS BAYNE ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 BEEHIVE PLACE COCKEYSVILLE, MD 21030 GRACE HYLE/DAUGHTER 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
DULANEY VALLEY MEM. 1 X Burial 2 ☐ Cremation 8/4/2008 4 Donation 5 Other (Specify) COCKEYSVILLE, MD GARDENS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21286 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine PNEUMONIA Due to (or as a consequence of): Physician/Medical SEPSIS IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 No 1 □ Yes 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7-31-08 D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LINTHICUM. RICHARD M_D 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
8/1/08 TT
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No.2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 30, 2008 Month **Physician** IN GrAM JULY 11:11FM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1 □ M 2 🛛 F Yrs. 216-18-4236 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 12 res 2 □ No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country ō or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 No 1 Never Married 2 Married 1 □Yes Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No If Yes, Give Year or Dates ģ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, it a Maone. Elementary/Secondary (0-12) College (1-4or 5+) DUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Inc 140 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or R ral Route Number, City or Town, State, Zip Code) 680 Guyn Tak NO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 10 Burial 2 Cremation 3 Removal from State 08 GARRISM livrest 7 00019 4 ☐ Donation 5 ☐ Other (Specify) 0 21. Scnature of Funeral Service Licensee 22. Name and Address of Facility Huneral Howell 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RUPTURED ANEURYSM disease or condition resulting in death) HOURS /Medical Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or se a consequence of): spital or Attending Physician: The law requires that the death certificate be executed ours after death, the cleath.

The law is presented on the attending physician and filled in by the tuneral director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burst-transit. attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 1 ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 N ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital on within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month. Dav. Year) D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

TABASSI.

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31. Date filed (Month, Day, Year)

M.D.

32. Registrar's Signature

A PROPERTY

7601 OSLER DRIVE TOWSON.

MARY

AND.

08-05300 Joyce E. Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Dyce E. Jones	.6	1- For State Control of Peat Therit of Peat Therit and Wentan Ay 1- For State Certificate of Death Registrar	Reg. No. 2008 2181
Physicia ledical Examin		1. Decedent's Name (First, Middle, Last) Source E Sones	2. Date of Death Month Day Year July 10, 2008 3. Time of Death 1512 hrs
1		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
٠, ١		601 Wyanoke Avenue Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	ė	2/3-76-/28/ 1 M 21/F 49 Yrs. Months Days Hours Min. Usual Residence of Decedent	9-16-1957 Foreign Maryland Country)
any		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland 28a-f show d at once.	힐	Md Baltimore	1 Vyes 2 No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tean 27 is marked other than "natural", or items 23a or 28a-f sho tranmatic event, the Medical Examiner must be notified at once.	Dire	10e. Street and Number 10f. Zip Code 601 Wyanoke Avenue 21218	10g. Citizen of What Country?
r death wit or items 2 must be n	Funera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 14. West Married 12. Was Decedent Ever in U.S. 14. Was Decedent of Hispanic Origin? (Sp. 15. West Decedent of Hispanic Origin?) (Sp. 16. West Decedent	Rican, etc.) White, etc.
urs after lural",	출 -	3 Widowed 4 Divorced If Yes, Give Yeer or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v	vork done 16b. Kind of Business/Industry
6 72 hou un "nat	etec	Elementary/Secondary (0-12) College (1-4 or 5+)) omestic
003 within grene. her thr	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maiden Surname)
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	Be	Leonard Harris Porott	ny Jones
y, MD 21215-00. and 2 should be filed with teath and Mental Hygiene ten 27 is marked other transmatic event, the Men	유		Rural oute Number, City or Town, State, Zip Code) Son PIC, Ave Batto Wel.
re, MD s 1 and 2 sho of Health and If item 27 is ter traumati	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
Page ent c		4 Donation 5 Other Specify: Boyview Coemotory	29/08 Backs. Md.
Baltimore, permit Pages I an Department of Her Important: If ite injury or other tr		21. Signature Funeral Cervice Licensee 22. Name and Address of Ficility // 1639 N & BROADER	ay Balto, Md. 21.213
Physician /Medical		23d. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arrest, shock, or heart Approximate Interval Between Onset and
xaminer	İ	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):	Death
, /		Sequentially list conditions, b	
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated C	
executed an and all - transit			
be exectician an unial - t	Medical	UNPENDED AMENDED	
876C ificate ing physis the bu	n/Me	IF FEMALE: 23b. Was decedent pregnant in the process of the second pregnancy o	23d. Date of delivery ancy Month Day Year
ox 6	sician/	past 12 months? 1 Yes 2 No 9 V Unknown g Unknown g Unknown	
D. B. t the de by the ached f	됩	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
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of \ing Phy	آ: آ		28d. Describe how injury occurred
Sion Attendi death ector:	catio	Natural 5 Pending Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Divi	Certification:	Suicide 6 Could not be determined (Specify)	or Town, State)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	calc	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	
To th within To th	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
	_	0.C.M.E.	July 31, 2008
		30. Name and address of person who completed cause of death (trem 23a)	4004
	nte.	Zabiullah Ali, M.D. Assistant Medicál Examiner 111 Penn Street, Baltimore, MD 21 31. Date filed (Month. Day, Year) 32. Registrar's Signature	1201
St Regist	ate rar	0 1 2002 Mars 15 10000	OCME

				e or Print in Black			•	•	ible.		
			1 - For State Registrar	ate of Maryland / De <i>C</i>	partment <i>Certificate</i>			giene Reg. No. 2 (800	24	813
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of De	eath	Year	3. Time of	
	/Medic	al	Mary Elizabeth Joyce 4a. Facility Name (If not institution, give stree	and number)	4h City To	wn, or Location of Death			y of Death	7:48	Рм
المجار	Examin	er	Suburban Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. last birthd	Bethe	sda		Mont	gomer		
	Funeral Director		577-42-4790 Usual Residence of Decedent		Months [Days Hours Min.	Sept.	13 ^(ear) 1908	Nort	ch Caro	of Foreign olina
Saitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exam har and to notified at once.	To Be Completed by Funeral Director	3 M Widowed 4 □ Divorced			Analyst 18. Mother's Nam Mary Oli treet and Number or Ru urst Road, of r place) Augu	pecify Yes or No o Rican, etc.) king ne (First, Middle, via Fra via Foute Numb. Bethesd Date 1,	United 14. Ra Ble Speci 16b. Kind of E Federa , Maiden Surna. zer er, City or Town a, MD 2	E T Dity or Town, State, Zip Code)		
	Physician //Medical Examiner		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	M01346 Institute that caused the death. Do not use on each line. Billion & A Due to (or as a consequence of):	Bethesd		·		Wisco	nsin A Approximat Interval Bet Onset and I	e ween
N. S. S. S. S. S. S. S. S. S. S. S. S. S.	executed n and al-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last b b b b b c d	Due to (or as a consequence of): Due to (or as a consequence of):							
C. BOX 6	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 burus after death certificate that burns alter death. After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burn that the property of the	Physician/Medical	in the past 12 menths?		3 □ Ectopic preg 5 □ Other <i>(sp</i> ec <i>i</i>				ate of delive onth	,	Year
<u>,</u>	es that igned to be deta	ò	Part II. Other significant conditions contribut	ing to death but not resulting in the	e underlying caus	e given in Part I.		obacco use con			
cords,	requii	eted	rarapnermonic EF	Fusion, Hypoxia	e respi	rating Failur		Yes 2 □ No			Unknown
ביי וג	: The law cate has page 2 :	Completed	- Strepto coccus Seps	is, Congrespa	thy,			an 24b. osy ormed? 2 No	Were autor prior to cor death? 1 Yes	psy findings npletion of c 2 □No	available ause of
T	siclan certif irector	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospit	al:		26. Place of Dear					
5	g Phy ter this teral di	ا ا	27. Manner of Death 28	a. Date of Injury 28b. Time	e of 28c.	Injury at	ome 5 Resident	dence 6 □Ot how injury occui		<u>/)</u>	
	or Attendin after death. Director: Af I in by the fur	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28	(Month, Day, Year) Injury B. Place of Injury - At home, farm, building, etc. (Specify)	М	Work? 1 □ Yes 2 □ No	28f. Location (5 City or Tov	Street and Num. vn, State)	ber or Rura	l Route Num	ber,
	he Hospita in 24 hours he Funeral pletely filled	ledical C	(Check only 2 Medical Examiner: (: To the best of my knowledge, de on the basis of examination and/or and manner stated.	eath occurred at t r investigation, in	he time, date and place my opinion, death occu	, and due to the rred at the time,	cause(s) and n date and place,	nanner as si and due to	tated. the cause(s	:)
	To t With Com	Ž	29b. Signature and title of certifier A	MO	29c. Li	cense number		29d. Date signe	8103	Day, Year)	
	20		30. Name and address of person who completed the second se	ed cause of death (Item 23a) (Typ	e, Print)	Hose.					
	Stat Registra		31. Date filed (Month, Day, Year) 2008	32. Registrar's Signature	ues.						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year 2008 2:40 SOUFIANO KAMAROU-DIN 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S 5. Social Security Number Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min Director 220-33-0503 OCT 17. 1961 GABON Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Director 1 ∑Yes 2 □ No PRINCE GEORGE'S DISTRICT HEIGHTS MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 USA 1918 ROCHELLE AVENUE #122 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Š 3 Widowed 4 Divorced Specify: "natural", BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RECEIVING CLERK YR PRIVATE Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be 9 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: If Item 27
any Injury or other tr.
once. PHYLLIS HARRISON / Friend 3828 Regency Parkway Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-01-2008 Suitland, MD Washington National 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 SUITLAND ROAD SUITLAND, MD 20746 Donald R. Gray 23a. Part Enter the disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The perform certificate 2 X No 1 ☐ Yes 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐ Yes 2⊠No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 I ER/Outpatient 3 I DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day, Year) 1 Natural 1 ☐ Yes 2 🗆 No 2 Accident after death Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide hin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one 29b. Signature and title 2 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a (ou HOSDITA 001 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2481 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 29 2008 Year Joseph Kidwell Sr 10:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Oak Crest village Parkville Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, December 9. Birthplace (State or Foreign **Funeral** 1 ₩ M 2 □ F Days 27 1926 Baltimore, Maryland 213 26 8543 81 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Evantiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Baltimore County 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd. Apt. 3306 21234 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No þ Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglenc Important: If Item 27 is marked other the any Injury or other traumatic event, Inspone Clerk CSX 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) William Allison Kidwell Sr. Winifred M. McHale 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8810 Walther Blvd. Apt. 3306 Baltimore, Maryland 2123 19a. Informant's Name/Relationship (Type. Print) Alice R. Kidwell Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery August 1 2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Lassahn Funeral Home Inc of Funer I Service Licenses 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Memorrhac disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Examine Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð seizure 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manpar of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, detached funeral director, page 2 should has this death.

21215-0036

Baltimore, Maryland

attending physician for use as the buria thours after death funeral Director: filled in by the 24 hours a Hospital

completely within 2

> State Registrar

29b. Signature and title of certifier

Block

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8800

Parhville, MD 21234

31. Date filed (Month, Day, Year)

(Check only one)

32. Registrar's Signature

08-05779		Please Type or Print in Black Indelible Ink.					ible.		
Julia Bohin Koch		State of Maryland / Department of He 1-For State Registrar Certificate of De		nd Menta			g. No.	200	
Physicia Medical Examir	110	Decedent's Name (First, Middle, Last) Julia Bohin Kochan						Year	3. Time of Death 1854 hrs
VON.		4a. Facility Name (if not institution, give street and number) 4b. Ci		r Location of			4c.	County of Death	
Funeral			attsville Jnder 1 Ye	ar If Under	24Hrs. 8.	Date of Birth		rince George	thplace (State or
Director			onths Da		Min.	ecember		Foreig	
		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					,		10d. Inside City Limits
d how any		Maryland Prince George's Hyattsville							1 Yes 2 X No
farylan 28a-f si Latone	Director	10e. Street and Number 10f.	. Zip Code			10	g. Citiz	en of What Cou	ntry?
th the N 23a or notified	•		20781					d State	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In it is a 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 14C VET IVIZITIES 2		ispanic Origi an, Mexican,			1	 Race - Amer White, etc. 	ican Indian, Black,
after de	by Fu	or Dates:	2 X N	o specify:			\$	Specify: Whi	te
hours 'natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				done	16b. K i	ind of Business/	Industry
D36 thin 72 ne. than '	Completed	12 Executiv	re Se	cretar	у	i	IB	BM	
15-0(filed wi Hygier d other , the M		17. Father's Name (First, Middle, Last) Michael Bohin				st, Middle, M	laiden S	Surname)	
21215-0036 uld be filed within 7 Mental Hygiene, marked other than	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add	ress (Stre		a Buc		ber, Cit	y or Town, State	e, Zip Code)
Baltimore, MD 212 permit. Pages I and 2 should by Department of Health and Ment Important: If item 27 is mark injury or other traumatic ever		Janice E. Kochan/Daughter 5624 Hog	genhi	ll Ter	race,	Rocky	vill	e, Mary	land 20853
of Hea		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Gate of Heav	(Name of c ace)		Da August			ocation - City or ver Spr	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	-	4 Donation 5 Other Specify: Cemeterv			2008	8	Mar	yland	77 b 1 199
Balt permit Depart Impor		M01360 Inc. 3							Home/Rockville and 20850-2805
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo- failure. List only one cause on each line.	ode of dyin	g, such as ca	rdiac or res	piratory arre	st, sho	ck, or heart	Approximate Interval Between Onset and
xaminer	ĺ	Immediate Cause (Final disease or condition resulting in death) a. Drowning complicating atherosclerotic Due to (or as a consequence of):	cardiova	ascular dis	sease				Death
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	an/Medi	IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal de	eath 3	Ectopic	pregnancy			I. Date of deliver Month	y Day Year
Box 6(e death cert the attendir	ਹ	past 12 months? 4 Pregnant at time of death 5 Other ((Specify)		, ,				
O, Be nat the ded by the setached for	Physi	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause	given in Pa	rt I.	23e. Did to	bacco u	use contribute to	the cause of death?
b, P.O. ires that the signed by t	d by	dementia				1 Yes	2 🗸	No 3 Pro	bably 4 Unknown
of Vital Records, ng Physician: The law require Wher this certificate has been si	Completed					24a. Was a autop			utopsy findings available completion of cause of
ital Recional Recional Recipiest Processing Italian Recipiest Precional Recipiest Precional Recipiest Precional Recipiest Precipiest	Com					1 🗸 Yes			es 2 No
Vital ysician his certi director	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	DOA DOA	Other	Nursing H		Reside	nce 6 🗸 Othe	er: Scene
n of \ding Phy n. After the funeral of	-	27. Manner of Death 28a. Date of Injury 28b. Time of Injury		jury at Work	Sui	d. Describe t	now inju	iry occurred	
Division spital or Attendit hours after death.	Certification:	1 Natural 5 Pending Investigation Jul 28, 2008 1845 hrs 2 ✓ Accident Superior Supe		Yes 2	No				ural Route Number, City
Divi	ertifi	Suicide 6 Could not be determined (Specify) Single Family	citory, office	, building, ex	502			attsville, MD	dia Route Number, City
To the Hosp within 24 ho To the Fune completely fi		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred a one)							
To th within To th	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated. 29b. Signature and title of certifier		nse number	corred at the	e time, date		Date signed (M	
		Lay Her mis		C.M.E.				29, 2008	, , , , , , , , , , , , , , , , , , , ,
7		30. Name and address of person who completed cause of death (Item 23a)					l		
1/2	o to	Tasha Greenberg MD. Assistant Medical Examiner 111 Per 31. Date filed (Month, Day, Year) 32. Registrar's Signature	nn Stree	t, Baltimo	re, MD 2	1201			
Regist	tate trar	31. Date filed (Month, Day, Year) AUG 0 1 2008 32. Registrar's Signature	100						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28,a-f per me, 2882,08/01/08/fine Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 24, 208 4c. County of Death une /Medical 4a. Facility Name (If not institution, give street and number) 4b/City, Town, or Location of Death **Examiner** Under 24 Hrs. 8. Date of Birth Jours Min. (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) 6. Sex **Funeral** Year) 1 ☐ M 2 🔀 F Months Days Hours Director March 14,1914 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the "section Event har marked an 1 1 Nos 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2121 WOOD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. Completed by Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r umbar Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 mue 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 21213 Ba aughter permit. Pages 1 and Department of Healt Important: If item 2 eny injury or other: 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 30-08 MI). butte 4 Donation 5 Other (Specify) 21. Stunature of Funeral Service Licensee 22. Name and Address of Facility 3405 W. lto: md. 2122 wallace Part Epter of disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or han failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) emenl **Physician** /Medical to (or as a consequence of): Examiner APPROVED BY MED Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner as a consequence of): signed by the attending physician and dbe detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown plnous Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an this certificate has al director, page 2 : autopsy 1 □ Yes 24 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2XNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral (28b. Time of P 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Natural 1 Natural
2 Accident Unknown_M 08/30/2006 Subject fell out of bed. death. 1 ☐ Yes X No I Director: / 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Bural Route Number City or Town, State) 1509 N. F.I Iwood 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide hours after Home Ave., Balto., MD within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

32 Registrar's Signature 31. Date filed (Month, Day, Year) 2008 AUG 0 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lovamea

Mohamed Yassin

St. # 308 Baltimore 821 N Eulaw

D00637/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Joseph F. LiPira, M.D. July 30, 2008 8:35 P. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Gilchrist Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months **1X**□ M 2 □ F Days Hours Director 215-14-0111 6/18/1923 Maryland 85 Usual Residence of Decedent 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2x No MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1004 Kirkcolm Road 21286 death v USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★★Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 72 hours after MXYes 2□No liYes, Give Year or Dates: Korean 1 ☐ Never Married 2 X Married 21215-0036 1 ☐ Yes 2 🗷 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Doctor-General Practioner Self Practice Department of Health and Mental Hygis Important: If item 27 Is marked other I any injury or other traumatic event, II once. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Vincent LiPira Concetta Cascio ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph LiPira/Son 9328 Perglen Road Baltimore, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) 8/4/2008 Cockeysville, MD Gardens and Address of Facility The Johnson Funeral Home, P.A. 21. Signature of Funeral Service Licenses 8521 Loch Raven Blvd. Towson, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Schemic Physician STEWS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-trans Due to (or as a consequence of): 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) o 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page perform Vital 1 □ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ot 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 🗆 No within 24 hours after death To the Fureral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JULY 31 2008 1 6701 N. Clurk St Towsw MD 21204
30 Registrar's Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAMIES UP 31. Date filed (Month, Day, Year)

ALIGO 1 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene Amend Items 23a,4a,b,c,25,27;; 28a-fof per ame, g882,08/01/08 dbb 1 - For State Registrar **Physician** 3:00 AM ton 2008 /Medical 4b. City, Town, or Location of Death

Baltimore eet and number) 4c. County of Death Examiner Hospice, 10WSOA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) Social Security Number last birthday) **Funeral** 1**X**M 2□ F Months Days Hours Min 241-07 -7686 Yrs Director Usual Residence of Decedent death with the Maryland 10a. State 10d. Inside City Limits City, Town or Location 28a-f show "natural", or items 23a or 28a-f shovidical Examiner must be notified at Reisterstown 1 ☐ Yes 2 No Funeral Director more 10g. Citizen of What Country? 10e Street and N 10f. Zin Code 21136 rive 1SF . Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Blac 1 ☐ Yes 2 ☐No Specify. þ Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Modical (Give kind of work done during life DO NOT use retired) Department of Health and Mental Hygiene. mportant: If item 27 is marked other than 'any Injury or other traumatic event, the Ma Elementary (Secondary (0-12) College (1-4or 5+) ranspor brd TCI Father's Name (First, Michie, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 0 470 Rual Route Number ormant's Name/Relationship ('y)e. Print) Daughter 19b. Mailing Ad ress (Street and Nac State, Zip Code 243 Keisters nartieu 20b. Place of Disposition cemetery, cremator 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State 21. Signature of Funeral Service uneral (2122 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ailure. List only one cause on each line. 23a. Part1. Ent ir the shock, or hear Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1/ 13Mas From Physician 0 aum /Medical Due to (or as a consequence of): Examiner CONTUSOR ON APPROVED BY MEDICAL EXAMINER Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Errling the burial-trar Due to (or as a consequence of): attending physician Box 68760 CERTIFICAT pe Physician/Medical ass IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. cate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 IMORACK SKINKYM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 1 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury ttural Accident 1 ☐ Yes 2 X No Unknown Unknown M death. Multiple falls within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ö Unknown Unknown To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LBU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 828 W MILLARE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 21 per fn,9882,08/18/08/25 of Death

Reg. No. 008-24820 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Margaret C. McClain 1 23°d 3:45 A M JUNE 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner SAINT AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min 1 □ M 2 🗙 F Yrs 214-34-4110 96 Director May 28, 1912 New York Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Directo Mary land Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3703 - 5th Street 21225 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: White ģ 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any Injury or other traumatic event, the Medicias (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12th State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Spaniol Jessie Lawrence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis McClain - Son 3703 - 5th Street, Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Holy Cross Cemetery June 26,2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway, Baltimore, MD 21225 21. Signature of Funeral Service Licensee Matt Hovatter per DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 13 days PNEUMONIA FILMON APPROVED BY MEDICAL EXAMINER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records. STROKE 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown ACUTE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No LEFT HIP FRALTURE autopsy performe FIBRILLATION ATRIAL Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1XYes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural Injury SUBJECT: FELL FROM CHAIR 06/09/2008 UN KNOWN M 1 ☐ Yes 2 X No 2 Accident To the Hospital or Attendential within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide BENSON AVENUE, BALTIMORE 3320 NURSING HOME Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Malling. A P22257 AUG 12th 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , SI-AGNES HOSPITAL, 900 S. CATON AVENUE, BALTIMORE MALLIKA . ANGITIPALLI MD- 21229 31. Date filed (Month, Day, Year) AUG 1 8 2008 32. registrar's Signature State Registrar

CLAIN

08-05863 David Mayes		Please Type of State - For State tegistrar	or Print in Blad of Maryland / I		of Health a		Hygiene	ible.	8 2482
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Las	avid Mar	105			2. Date of Death Month July 31, 200	Day Year	3. Time of Death 1410 hrs
ro-	ľ	4a. Facility Name (if not institution, given	on, give street and number) 4b. City, Town, or Location of De				4c. County of Death		
Funeral Director	7	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months, Days Hours Min.							
Director	ŀ	Usual Residence of Decedent							
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. The file of Health and Mental Hygene ant: If item 27 is marked other than "natural", or items 23a or 28a f show any or other traumatic event, the Medical Examiner must be notified at once.		10a. State 10b. County Maryland A	1/A- 1	Oc. City, Town or Loca	ation	Battino	re		10d. Inside City Limits 1 Pres 2 No
	Director	10e. Street and Number	LAve. A	ot.B	10f. Zip Code	21239	10	g. Citizen of What Coun	try?
	Funeral	11. Mantal Status 1 Never Married 2 Mam'ed	12. Was Decedent E Armed Forces? 1 Yes 2	No If	Yes, specify Cut	ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,
	ted by	3 Widowed 4 Divorcer 15. Decedent's Education (Specify of Elementary/Secondary (0-12)	or Dates:	leted) 16a Decede		pation (Give kind life. DO NOT use		Specify: DKA 16b. Kind of Business/Ir	ndustry
	Completed	17. Father's Name (First, Middle, Lasi			<i>Materia</i>	il Cotte	me (First, Middle, M	Werdell aiden Sumame)	extile
21215-0C Juld be filed wii Mental Hygien marked other:	8	Judies May.	05	10b Maili	ng Address (Si	Domi		ngton per, Oity or Town, State,	7in Codo) 4: 1 74
MD 2 nd 2 shoul of the and N n 27 is in aumatic	2	Dorris Mayes.	- mother	1703	Shen	wood A	ve. Apti	B Baltim	ore Maryland
Baltimore, MD 21215-00; permit Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: Irliem 27 is market other injury or other traumatic event, the Med		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specific		20b. Place of Disponsion of Communicatio		Mem.	8/7/08	Timenum,	Maryland
Baltimo permit Page Department Important: injury or of		21. Signature of Funer Service Lice	arken	3	Name an ddr	ess of Facility a	rker Fure	ral me	12 21229
Physician /Medical		23a. Part i. Enter the see, or comfailure. List only one cause on e	ach line.				c or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause								
scuted .	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):							
exe ian	-	UNPENDED	AMENDED	-					
Records, P.O. Box 68760, The law requires that the death certificate be excistle has been signed by the attending physician page 2 should be detached for use as the burial.	sician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at ti	2	Fetal death Other (Specify)	3 Ectopic pre	gnancy	23d. Date of delivery Month) Day Year
O. Bo It the dea by the a	된	Part II. Other significant conditions	9 Unknown	but not resulting in the	underlying cau	derlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death?	
S, P.(puires than an signed	ted by	chronic alcoholism					1 Yes	2 No 3 Prob	ably 4 Unknown
Record The law rec cate has bee	Completed						autops perfori	sy prior to o med? death?	completion of cause of
of Vital ing Phystcian: After this certif uneral director,	o Be (25. Was case referred to medical examiner?	Hospital: 1 Inpatien	t 2 ER/Outpatie		Other Nu		Residence 6 🗸 Other	: Scene
	\vdash	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Yea	28b. Time o	f Injury 28c.	Injury at Work?	-	ow injury occurred	
Division of Npital or Attending Phours after death. reral Director: After tiffled in by the funeral	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specific) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specific) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the !	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
To with	Mec	29b. Signature and title of certifier	and manner stated.		29c. Lic	ense number	OCME	29d. Date signed (Mo	
1.		Modern M. A	completed cause of de	ath (Itém 23a)	0.	C.M.E.		August 1, 2008	
X		Theodore M. King, Jr., M	D. Assistant Me	edical Examiner	111 Penn	Street, Baltim	pre, MD 21201		
St: Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrars	Generaline	the state of the s				

08-05620 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Spencer Melton 2008 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 2316 hrs July 22, 2008 **Medical Examiner** Dencer c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Windsor Mill **Baltimore County** 7010 Upper Mills Circle If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Days Director 12-25-775 1 M Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 or items 23a or 28a-f show must be notified at once, Marylar **Funeral Director** 10f. Zip Code 10g, Citizen of What Country 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black 11. Marital Status White, etc. Armed Forces? 1 Never Married 2 Yes Divorced If Yes, Give Year Yes 2 No specify: Widowed ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) 21215-0036 ould be filed within 72 h Elementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other than her traumatic event, the Medical Disable permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) JONES Delores Jackson Be Jem 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Baltimore, MD Kenwood 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) 2 Cremation 3 Burial Removal from State Cremat 70 Other Specify: Donation 5 21. Signature of Funeral Service Licens Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear proximate Interval Between Onset and failure. List only one cause on each line Medical aSeizure disorder Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED 23a,27, perME, g882 8/20/08 TT X UNPENDED been signed by the attending physician hould be detached for use as the burial Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Live birth Fetal death Month Day Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed After this certificate has been in funeral director, page 2 should 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other₄ examiner? Hospital: Nursing Home 5 Inpatient 2 ER/Outpatient 3 Residence 6 V Other: Scene 1 V Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Division Yes 2 No Pending Director: Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide within 24 hours a To the Funeral determined (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

29c. License number

O.C.M.E

State Registrar

July 23, 2008

29d. Date signed (Month, Day, Year)

Registrar

State

Baltimore

MO

W.B. Greenoughte MS

32. Registrar's Signature

0 1 Year 2008

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 31 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stree er itaa If Under 1 Year | If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F Months Hours Director 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show notified at 1 ☐ Yes 2 📉 No res Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? ns 23a or 2 must be n SH death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, or items Examiner Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Iter 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 Tyes 2 No Specify: Specify: Whit 3 Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) own home Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Ł√ans 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2008 Blackhorse, mo NewPort Dr. Forest Hill, mD 21050 21. Signature of Funeral Service Ligensee epm Evans Funera chane of Cremation Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** AMKINSONS Years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day 5 ☐ Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Dunknown 1 ☐ Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 HNo To the Hospital or Attending Physician: 25. Was case referred to medical ASSISTER 26. Place of Death (Check only one) Other: CARE 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6-Other (Specify) Certification: To After this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident within 24 hours after death.

To the Funeral Director; A completely filled in by the fi 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 31, 2008 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel AIN, MD21014 MACPITAIL SPARKS SLFRED 615 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\begin{align*} \be Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 50 P M Janie na M SOOS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1**x** M 2 □ F Months Days Hours 363-48-7942 61 Michigan **Director** Oct.28,1946 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show MD Baltimore 1 ☐ Yes 2 XNo ESSEX must be notified Director the 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with trent of Heath and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or : 1432 Galena Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: à Specify: White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Fire Department EMS Tech 12th Ith and Mental Hygie 27 is marked other r traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas MArkham Annabelle Leesch ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Luanne Szymanski /sister 1432 Galena Road Baltimore MD 21221 Department of Health Important: If item 27 any Injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 31/08 Bayview Crematory Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave.Balto. MD Connelly Home of Essex Funeral Part 1. Enter the disease or complete spock, or heart failure. List only on Approximate Interval Between Onset and Death ations that caused the death. cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final neumonia **Physician** month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner for lung transplant -mmunosu if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tra and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the the 98 IF FEMALE: use 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month gned by the atter be detached for Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 **N**0 Yes 1 🗌 Yes certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 1 npatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 1 Anatural 2 Accident 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospide North Wolfe St, Baltimore, MD, 21287 Johns

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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2008

2. Registrar's Signature

stacia Malone	1- For State Certificate of Death									
Physicia	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death								
edical Exami	ner	Lastacia C.Maione July 26, 2008 07/2 ms								
· A		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A								
Funeral Director		5-Secial Security Number 2 6. Sex 17. Age (In yrs. last birthday) 16 Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Months Days Hours Min. Mar. 10, 19 2 Country)								
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death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e Street and Number 2457 Druid Hill Avenue 21217 10g. Citizen of What Country? USA								
th with	unera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Married 2 Married 3								
E : E	щ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: Black								
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21215-0036 uld be filed within 72 Mental Hygiene. marked other than c event, the Medical	Be	Amos Malone Betty Johnson								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner	7	19a. Informant's Name/Relationship (Type, Print) Lynn Galloway/ Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2457 Druid Hill Avenue Baltimore, Md 21217								
re, r : 1 and f Healt f item er trau	II P	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State								
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Balt permit Depart Impor injury		21. Signature of Funeral Service Logister 22. Name and Address of Facility Chatman-Hsrris Funeral Hom 5240 Reisterstown Rd Baltimore, Md21215								
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Boy e death the att	hysi	1 Yes 2 No 9 V Unknown g Unknown								
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fineral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One								
To To Com	Medical	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)								
		Jan See 2008 O.C.M.E. July 26, 2008								
(1)		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
V		31 Date filed (Month Day Year) 32 Registrar's Signature								

Registrar

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			State Registrar				tificate of		mornar ri	Reg. No	000	8 24827	
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Total Control			20016 Lake Park 5. Secial Security Number 6. Sec		e (In yrs. las	t hirthday)		antown If Under 24 Hrs	8 Date of B	irth	Montg	omery Birthplace (State or Foreign	
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	th with		20016 Lake Parl	k Drive			208	74		1	United	States	
	items ?	Funeral	TT Walter Olales	12. Was Decedent Armed Forces?		13. \	Was Decedent of f Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-	14. Race - A Black, W	merican Indian, hite, etc.	
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mo	Pages nent of int: If I		1 ➡ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		1		Cemete:	i.	t 4, 2008	Gern	antown	n, Maryland	
Baltimore, Maryland	permit. Pages 1 Department of I Important: If Ite any injury or ot		21. Signature of Funeral ervice Li	ee		22	Name and Addr	ress of Facility					
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R	The law cate has page 2 a	Com							perf	opsy formed? 2 🏿 No	death	to completion of cause of n? ∕es 2 □ No	
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:			10	26. Place of De	ath (Check only	one)			_
of		7: To	1 ☐ Yes 2 ☐No 27. Manner of Death	28a. Date of inju	iry 28	8b. Time of	1 3 DOA		lome 5 ☑ Res			pecify)	_
ion	E # : 9	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y, Year)	Injury	Wo	ork?]Yes 2∐No		·	•		
Division	I or Attend after death Director: / d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubul	ury - At home c. (Specify)	e, farm, stre	eet, factory, office		28f. Location City or To	(Street ar wn, State	nd Number or e)	Rural Route Number,	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th		29a. Certifier 1 Certifying Physics	sician: To the best	of my knowle	edge, death	occurred at the	time, date and plac	e, and due to th	e cause(s) and manne	r as stated.	- 1
	To the He within 24 To the Fu	Medical	(Check only 2 Medical Exami	and manner sta	ated.	n and/or in			urred at the time				_
	5 6 00	,	29b. Signature and title of certifier	45	-			se number				onth, Day, Year)	
	12		30. Name and address of person who co	ompleted cause of d	eath (Item 2	3a) (Type, I		3083		J	uly 31	, 2008	_
	10		George A. Sotos,	M.D. 970	7 Med			rive Sui	te 300 I	Rockv	ille,	MD 20850	
	Sta Registr		31. Date filed (Month, Day, Year) ALIG 0 1 2	OOG 32. Hegistr	ar's Signatur	Ch A	Center D						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Miller A. Murray, Jr. 27 8% 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. agnes 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral №** M 2□ F 214-56-8241 56 Yrs. Director Jan. 10. MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shore Baltimore MD 1 x Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3504 W. Franklin Street 21229 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 ₩No Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) mechanic (auto) self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any Injury or other traumatic event Be Miller A. Murray, Sr. Ernestine Murray 19a. Informant's Name/Relationship *(Type. Print)* Jovan L. Murray—Walker / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 Cotswold Ct; Baltimore, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park 07/31/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complica shock, or heart fallure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner 2 days Sequentially list conditions, Examiner d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fur as a conseque physician are the burial-t Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Vear 5 Other (specify) I ☐Yes 2 ☐ No 9 Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed icate has been ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manney of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 22258

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Caton

32 Registrar's Signature

Mola

31. Date filed (Month, Day, Year)

Ave

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar 24829 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ^{Day} 2008 Arvind K. Nayar 29, July 10:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Hours 1 ₹ M 2 □ F Months Days Min 65 091-48-8974 Director April 10, 1943 India Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Expriner must be notified at 10d. Inside City Limits Director 1X Yes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 11513 Alcinda Lane 20878 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ Specify: Asian Indian 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Education Dental Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Motitiram Nayar Vimla Jeradh 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is n any injury or other traun Ankush Nayar/Son 11513 Alcinda Lane, Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Bethesda, MD 22. Name and Address of Facility Robert Bethesda-Chevy Chase, Bethesda, MD 20814 Pumphrey Funeral Home/ . 7557 Wisconsin Ave. of Funeral Service Licensee A. P Inc. M01346 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) eumou /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, coding to immission cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of, law requires that the death certificate be executed Exami burial-tran and resulting in death) Last Due to (or as a consequence of) physician at the burial Box 68760, Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a P.0. 1 Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ certificate has been si irector, page 2 should ! ovana 1XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D38262 July 29, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anurita Mendhiratta, M.D., 2401 Research Blvd. #330, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

08-05342 Turner Jordan N	مادم		or Print in Black II of Maryland / Dep					ible.	
rumer cordain re		I- For State Registrar		rtificate of L		Mentarry		. No. 2	008 2483
Physici	an/	Decedent's Name (First, Middle,Las					2. Date of Death Month	Day Year	3. Time of Death
Medical Exami		4a. Facility Name (if not institution, giv		urner Joh	rdan Nel		July 12, 200	98 4c. County of	0857 hrs
1		2609 Leahy Street	s street and number		Baltimore	ocalion of Docum	e jit		500
Funeral		5. Social Security Number 6. Se		last birthday)	tf Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth	(MM/DD/YYYY)	Birthplace (State or Foreign Country)
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any	•	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location	1				10d. Inside City Limits
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ith the Maryland 23a or 28a-f show notified at once	Director	10e. Street and Number	`		10f. Zip Code	~	100	g. Citizen of Wha	
ith the		6750 Ransome	12. Was Decedent Ever in U	13 Was	ZIZO	anic Origin? (Spe	ocify Ves or No-	U. 5.	American Indian, Black,
leath w	Funeral	1 Never Married 2 Married	Assess Casasan			Mexican, Puerto F		White	
after c	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		es 2 X No				Black
hours "natur		15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)			on (Give kind of we DO NOT use retire		16b. Kind of Bus	iness/Industry ·
D36 thin 72 ne. than edical	Completed	O O	college (1-4 of 5.)	N,	/A			N/A	
215-0036 be filed within 7 intal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)	1		18	8.Mother's Name	4 6	,	V (#
2121 vuld be f Mental markec c event,	To Be	Stephen Ne	vpe Print)	19b. Mailing A	Address (Street	Natis V			, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Métall Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Natisha Johnson		16750		ne Dr.B			
re, rand f Healt f Healt f Firem		20a. Method of Disposition 1 Burial 2 Cremation 3	20b	Place of Disposition	on (Name of ceme	etery,	Date	20c. Location -	City or Town, State
Baltimore, Descript Pages 1 and Department of Her Important: If ite		4 Donation 5 Other Specify	/	verdale P	ark Creme	atory 7/3	30/08	River	dale MD
Balt permit Depart Impor injury		21. Sonature of Funeral Service Vcer	sed /	22. Na	me and Address o	of Facinty	1 500	_	14 upshur 5t Nu vash DC.
Physician		23a. Part I. Enter the disease, or comp		h. Do not enter the	mode of dying, s	such as cardiac or			rt Approximate Interval
/Medical		failure. List only one cause on ea Immediate Cause (Final disease a.	och line. Drowning						Between Onset and Death
/ CAMITICI		or condition resulting in death)	Due to (or as a consequence	of):			1		
	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):				9.1	
نهن	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):					
and transit	alEX	d.		000	0./1./00	min.			
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Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be extending 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be extending 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	sician/Medic	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pre	gnancy	I death 3	Ectopic pregnar	псу	23d. Date of Month	delivery Day Year
or use	sicia	past 12 months?	4 Pregnant at time of c		er (Specify)				
D. Be the de by the	Phys	Part II. Other significant conditions	Unknown contributing to death but not	resulting in the un	derlying cause giv	ven in Part I.	23e. Did tot	pacco use contri	bute to the cause of death?
ords, P.O. I	ē		-				1 Yes	2 🗸 No 3	Probably 4 Unknown
Division of Vital Records, rat or Attending Physician: The law requiring and reter death. There is certificate has been silled in by the funeral director, page 2 should bled in by the funeral director, page 2 should be	Completed						24a. Was a		Vere autopsy findings available rior to completion of cause of
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of Vi Physicer this eral dir	욘	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of Inj				Residence 6 vo	
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Cert	4 V Homicide determine	(opean)/ Nivel			1	Found, Pataps	co River off S	eagirt Term., Baltimore , MD
the Ho in 24 h	Medical		ian: To the best of my knowle r:On the basis of examination						
To 1 with To 1	Med	29b. Signature and title of certifier	and manner stated.		29c. License			_	ed (Month, Day, Year)
		Carde 1	fallon		O.C.N	И.Е.		July 12, 20	08
7		30. Name and address of person who			I	- MD 0463			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Carol Allan, MD Assista 31. Date filed (Month, Day, Year)	ant Medical Examiner 32. Registrar's igna		reet, Baltimo	ore, MD 2120	1		
S		ALIC 0 1 2008	Below D	The said					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** OTTO 8:SIAM GARY 37 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** SORT hwes TOSPILA AndallsTown Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Days Hours Director 27,1944 West Virginia 234-66-8373 June Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Baltimore Glyndon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 Waugh Ave 21136 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1962
If Yes, Give 1962 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1962-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 1968 White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Producer/Director Television 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Charles Francis Otto Thelma Louise Strine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Denise D. Otto Wife 25 Waugh Ave. Glyndon, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/4/08 Carroll Cremation Hampstead, MD Service License 21. Signature of Fund 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. I Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Physician Carl /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in modat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Division or Vital Records, P.O. Box 687607 or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) n signed by the a ld be detached f 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ertension 1 | Yes 2 | No 3 | Probably 4 Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes perform 1□ Yes 2□ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 🗌 Inpatient 2 R/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After s after deam. 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral D

completely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D0054558 hysiciAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old COURT Rd RANDALISTOWN, MO 21133 YEDERICK

State Registrar

BURKE, JR, MO 2. Registrar's Signature 31. Date filed (Month, Day, Year) 2008 1 0

08-05728 Angelia Louise Phillips	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	108 24832
1-	For State Certificate of Death Reg. No.	
Physician/ 1 Medical Examiner	Decedent's Name (First, Middle,Last) Angelia Phillias 2. Date of Death Month Day Year July 26, 2008	3. Time of Death 0614 hrs
	Saint Agnes Hospital 4b. City, Town, or Location of Death Baltimore 4c. County or	Death All A
Funeral 5	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY)	Birthplace (State or Foreign Country)
Director	244-19-6643 1 M 2 F 34 Yrs. Months Days Hours Min. June 20, 1974	N. Carolina
w any	10a. State 10b. County N/A 10c. City, Town or Location Bullimore	10d. Inside City Limits 1 Yes 2 No
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Firen 27 is marked other than "natural", or items 23a or 28a-f show ritem 27 is marked other than "natural", or items 23a or 28a-f show ritangalic event, the Medical Examiner must be notified at once. To Be Completed by Furneral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of Wh	at Country?
with the ns 23a o pe notifi	11. Walital Status	- American Indian, Black,
r death with or items 23 : must be no	1 Never Married 2 Married 1 Yes 2 No	Black
ours after attural?	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify	
5-0036 led within 72 hours after Hygiene other than "natural"; the Medical Examiner Completed by I	Elementary/Secondary (0-12) College (1-4 or 5+) Security Guard Admir	al Security
21215-0036 ald be filed within 72 marked other than event, the Medical o Be Comple	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 11. Father's Name (First, Middle, Maiden Surname)	
D 2121(should be fill and Mental h 7 is marked natic event, j	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow	n, State, Zip Code) 21229
nore, MD 2 ages I and 2 shou nt of Health and N tt: If item 27 is n other traumatic	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Lecation	- Citt or Town, State
<u>ರ</u> ್ಣಿ ಕೃತ್ವ	4 Donation 5 Other Specify: Arbutus Mem. Park F-2-08 Arbutus	tus, Maryland
	21. Signature of Funeral Servic. Judensee Payler 3572 Frederick Ave. Battimere, N	laryland 21229
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line.	Approximate Interval Between Onset and Death
yaminer	Immediate Cause (Final disease or condition resulting in death) a. Inhalation of Smoke and Soot Due to (or as a consequence of):	
	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
E E	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	
4 m in m in m	d. UNPENDED AMENDED	-
t 68760, certificate be ending physician use as the burial cian/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial ledical Certification: To Be Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (Specify) g Unknown	Day Year
O. Box nat the death deby the atterted for unity Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	ribute to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detachertification: To Be Completed by Perentification: To Be Completed by Perentification:	24a. Was an 24b.	Were autopsy findings available
Records, The law require, ficate has been sig, , page 2 should be	performed?	prior to completion of cause of death? 1 ✓ Yes 2 No
tal R cian: Tl certifica ector, pa Be Cc	25. Was case referred to medical examiner?	
F Vit	examiner? 1 Ves 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occur	Other:
ision of Vital Attending Physician: r death rector: After this certil by the funeral director ication: To Be	1 Natural 5 Pending P	
Division o spital or Attending tours after death meral Director: Aft filled in by the fune	3 Suicide 6 Could not be or Town, State)	per or Rural Route Number, City
Divi	4 Homicide determined (Specify) Townhouse / Rowhouse 143 South Morley Street, B. 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner	er as stated.
To the Ho within 24 P	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.	due to the cause(s)
, , , ,	29b. Signature and title of certifier 29c. License number 29d. Date sig O.C.M.E. July 26, 2	ned (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)	
- ' /	Russell Alexander MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	31. Date filed (Month, Day, Year) AUG 0 1 2008 82. Registrar's Signature AUG 0 1 2008 OCME	

08-05801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert Poremsk		State of Maryland / Department of He 1-For State Certificate of De Registrar			. No. 200	8 2483
Physici ledical Exami	an/	1. Decedent's Name (First, Middle,Last) Robert Poremski		2. Date of Death Month July 29, 20	Dav Year	3. Time of Death 1319 hrs
policide .		4a. Facility Name (if not institution, give street and number) 4b. C	city, Town, or Location of Dea		4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	olumbia Under 1 Year If Under 24H	frs. 8. Date of Birth	Howard (MM/DD/YYYY) 9. Bird	hplace (State or Foreign
Director		1 XM 2 F 30 Yrs.	lonths Days Hours M	Aug. 22		MD
v any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show d at once.	ig	MD Baltimore Baltimore	f. Zip Code		g. Citizen of What Cour	1 Yes 2 No
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	Dire	7210 Gough Street	21224	10(USA	ioy:
eath with items 23	Funeral	1 Never Married 2 Married Armed Forces? If Yes, s	cedent of Hispanic Origin? (pecify Cuban, Mexican, Puer		14. Race - Ameri White, etc.	can Indian, Black,
after de 'al", or	by Ft	3 Widowed 4 X Divorced If Yes, Give Year 1 Yes	No specify:		, ,	ite
2 hours after "natural", I Examiner	ted	Flementary/Secondary (0-12) College (1-4 or 5+) during most of	sual Occupation (Give kind of working life, DO NOT use r		16b. Kind of Business/i	
5-0036 led within 72 Hygiene. other than '	Completed	12th	ruction		Concr	ete
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Robert Richard Poremski		me (First, Middle, M ra Carte	· · · · · ·	
MD 21218 d 2 should be fill the and Mental H n 27 is marked anmatic event, I			dress (Street and Number of Gough Street	or Rural Route Numb	er, City or Town, State	
		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State crematory or other p		Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Doction 5 Other Specify: Bayview	Crematory 7	/31/08	Baltimo	re MD
Baltimo permit. Page Department Important: injury or otl	8	Thirty of the	e and Address of Facility Connelly Full		Ave. Ba	
Physician		26a. Part I. Enter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each life.	ode of dying, such as cardiac	c or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical = xaminer		Immediate Cause (Final disease a. Hanging or condition resulting in death) Due to (or as a consequence of):				Death
	<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Dicease or knjury that in Itiated c.				
cuted .nd transit	E Xa	events resulting in death) Last Due to (or as a consequence or):				
O, the exe sician a	Medical	UNPENDED AMENDED				
OX 68760, eath certificate be executed attending physician and for use as the burial - transit	an/M	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal d	eath 3 Ectopic preg	gnancy	23d. Date of deliver Month	y Day Year
30x (death ce attended for use	Physician//	1 Yes 2 No 9 Unknown g Unknown	(Specify)		V.	l
that the d	by Ph	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	,	pacco use contribute to	-
rds, F requires t been sign hould be	ted t			24a. Was a	2 ✓ No 3 Pro	oably 4 Unknown
Records The law requi	Completed			_ autops perforr 1 ✓ Yes 2	ned? death?	completion of cause of es 2 No
Vital Reorgisician: The his certificate director, page	Be Co	25. Was case referred to medical examiner?	26.Place of Death (Che			35 2 110
f Vit Physic er this c eral dire	욘	1 Ves 2 No Inpatient 2 VER/Outpatient 3			Residence 6 Othe	r:
ion of rending Pheath.	tion:	1 Natural 5 Pending FOUND:	1 Yes 2 ✓ No		with a jumpsuit	
Division of Vital Records, P.O. Box 68760, fo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Could not be determined (6000)	ctory, office building, etc.	28f. Location (Son Town, St. PO Box 700, J	ate)	ıral Route Number, City
To the Hospii within 24 hour To the Funer		29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred a		and due to the cause	e(s) and manner as stat	
To the within 7 To the complete	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated. 29b. Signature and title of certifier	29c. License number	d at the time, date a	29d. Date signed (Mo	
-		had there is	O.C.M.E.		July 30, 2008	,,,,,
		30. Name and address of person who completed cause of death (Illem 23a) Dupon Manager M.D. Application to Medical Examinary 1111 December 11111 December 1111 December 1111 December 11	nn Stract Dalling	MD 24204		
	tate		nn Street, Baltimore,	IVID 2 120 1		
Regis				135	-23	
DHMH 17 Rev 1/2	2001	ORIGINAL		- 00	WE	

1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Month **Physician** Day RISCI LLA LOVSKY 5.30 PM ゴンレン /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOUPITAL 12ANDOLLS TOWN NORTH WEST BALTINORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 N F Days Min. Months Hours 218-12-0168 83 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Exactine institution office at Director 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 2805 BARTOL AVENUE 21209 USA Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō 1 □ Yes 2 No WHITE Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY STATE OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LOUIS FLAXMAN YETTA DORF 2 injury or other traumatic permit. Pages 1 and 2 shoul Department of Health and Mi Important: If item 27 is mark any injury or other traumath once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN VICK / DAUGHTER <u> 2805 BARTOL AVENUE, BALTIMORE, MD</u> 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State BETH EL MEMORIAL PARK: 08/10/2008 4 ☐ Donation 5 ☐ Other (Specify) RANDALLSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death)) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? After 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation eral Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) MD D0066357 2008 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Division of Vital Records,

VENKATA

MORTHWEST

ICEDDIVARI

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5 50 **Physician** TULY 2008 ALBERT POTTER Η. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BELAIR HEALTH AND REHABILITATION CENTER HARFORD BELAIR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1X M 2 ☐ F 55 MARYLAND Director 219-56-6319 AHG 3 1952 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show "natural", or Items 23a or 28a-f shoved and examiner must be notified at 1 ☐ Yes 2 No Director ABERDEEN HARFORD CO MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21001 Funeral 41 VALLEY BOTTOM RD. death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itel 1XXes 2 No If Yes, Give Year or Dates: 73/79 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2KXIo þ Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT DOL 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ MARIE R. HAWKINS LINWOOD JONES 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyne A. Potter/Wife Valley Bottom Rd., Aberdeen, Maryland 21001 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any Injury or o once. 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 08-04-08 OWINGS MILLS, MARYLAND 21. Signature of Funeral Service Lice william C Brown COMM FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conseque ce of): **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? muma 20 No 1 ☐ Yes 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No s certificate has be lirector, page 2 s autopsy perform or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this after death.

I Director: After this d in by the funeral d 28a. Date of Injury 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 2 Accident 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cert 29c. License number 29d, Date signed (Month, Dav. Year) who completed cause of death (Item 23a) (Type, Print) 308

DHMH 17 Rev 1/2001

State

Registrar

31 Date filed (Month, Day, Year,

AUG 0 1

2008

32. Registrar's Signatur

y Plimack		State of Maryland / Departme 1- For State Certifica Registrar			lygiene Reg.	No. 20	08 2483				
Physicia dical Examir	ın/	Decedent's Name (First, Middle,Last)	PLIMA		2. Date of Death	ay Year	3. Time of Death 1138 hrs				
,		4a. Facility Name (if not institution, give street and number) Northwest Hospital		4b. City, Town, or Location of Death	<u> </u>	4c. County of Dea Baltimore Co					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1 X M 2 F 52	nday) Yrs.	Months Days Hours Mir		MM/DD/YYYY) 9. B Fore					
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town c					10d. Inside City Limits 1 Yes 2 X No				
the Maryland sa or 28a-f show	Director	MD BALTIMORE BALT 10e. Street and Number	IMOI	RE 10f. Zip Code	10g.	Citizen of What Co	izen of What Country?				
death with the Maryland or items 23a or 28a-f sho	Funeral Di			21208 s Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerto		14. Race - Ame White, etc.	A erican Indian, Black,				
s after deat ral", or ite	by Fun	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 No specify:		Specify:	WHITE				
7; NLO Z 1 Z 1 2-10-00-00 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Completed			t's Usual Occupation (Give kind of ost of working life. DO NOT use ref		6b. Kind of Business	ETAIL				
Z1Z13-0030 zuld be filed within 7 l Mental Hygiene. marked other than ic event, the Medica	Be Com	17. Father's Name (First, Middle, Last)	[MACI	18.Mother's Nam	e (First, Middle, Ma						
e, MD Z 1215-005. and 2 should be filed with lealth and Mental Hygiene. item 27 is marked other th	T	19a. Informant's Name/Relationship (Type, Print)	. Mailing	Address (Street and Number or STEVENSON ROAD	Rural Route Number	er, City or Town, Sta	te, Zip Code)				
2 2 2 2 2 E		20a. Method of Disposition 1	of Disposi Ory or oth	ition (Name of cemetery, her place) RE HEBREW 07/		20c. Location - City o					
		21. Signature of Funeral Service Licensee Mark Level Company of C	89	OO REISTERSTOWN	ROAD - P	ON & BROS					
hysician /Medical Examiner		3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Fentany1 intoxication roudition resulting in death) Due to (or as a consequence of):									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause									
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te be executed ysician and burial - transit	ledical	X UNPENDED AMENDED 23a 27, 28a IF FEMALE: 23c. If yes, outcome of pregnancy	-f ₈₈	33e5 F 157082 T 177	08 TT	23d. Date of delive	20/				
e death certificate the attending phy ed for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 1 Unknown		tal death 3 Ectopic pregn	nancy	Month	Day Year				
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ne law requi te has been ge 2 should	Completed				24a. Was an autopsy perform	prior to ed? death?	autopsy findings available completion of cause of Yes 2 No				
hysician: Th this certifica I director, pa	o Be C	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Ou	utpatient	26.Place of Death (Check 3 DOA Other Nurs		esidence 6 Oth	ner:				
Attending Phyrdeath. r death. ector: After tl by the funeral	Certification: T	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred									
Hospital or / 24 hours after Funeral Dire		4 Homicide determined (Specify) residence description of the determined (Specify) residence description of the determined (Specify) residence description of the determined (Specify) residence description of the determined of the	denc	e	or Town, Star 8420 Ste	_{te)} venson Rd	Pikesville				
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.			at the time, date an		the cause(s)				
, or)	_	Uplus Brassell MD		O.C.M.E.		July 30, 2008					
) Drog			111 P	Penn Street, Baltimore, MD	21201						
Sta Regist	ate rar	31. Date filed (Month), Day, Year) 32. Registrar's Signature	6	West							
H 17 Rev 1/20	001	OR	IGINA	L							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Wayne J. Passon 30 09:35 AM July 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Stella Maris Hospice Baltimore Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☑ M 2 ☐ F Months Days Hours Min. 215-42-6915 Yrs. 63 Director April 10 1945 Usual Residence of Decedent 10a. State 10h County 10c, City, Town or Location 10d. Inside City Limits 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Predical Examinar must be realing an 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 114 Brookebury Drive Apt. 2C 21136 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 🙀 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) 10 Service Air Craft US Airway 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Passon Maria Triano ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trau Christopher Passon (son) 3103 St Paul Street Apt 2R, Baltimore, Md 21218 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aug. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Baltimore, Maryland 2. Name and Address of Facility 21. Signature of Funeral Service Licersee Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACQUIRED IMMUNE DEFICIENCY SYNDROME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consecuence of: Examine certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) HOSPICE Hospital: 1 ☐ Yes 2**X** No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. 28d. Describe how injury occurred Injury at Work? Hospitai or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical od title of certifier 29b. Signatur 29d. Date signed (Month, Day, Year) 29c: License number

State Registrar

DHMH 17 Rev 1/2001

2008

WAYNE PASSON

ORIGINAL

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

ddress of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

DR. ERNESTINE WRIGHT

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** :45A.M aare SCYS /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE Inga are If Under 24 Hrs. last birthday) Birthplace (State or Foreign Country) 7. Age (In yrs. **Funeral** Days Hours Min. Months 2 BALTIMORE MA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director PALTIMORE 10e. Street and Number 10g. Citizen of What Country? or items 23a or 2122C JSA COUR 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White 3 Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. important: if them 27 is marked other then "nai eny injury or other traumatic even". Elementary/Secondary (0-12) College (1-4or 5+) Homemak 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Igains 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zlo Code) daughter Nargare T 20a. Method of Disposition WP 91990 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, NO 21234 21. Signature of Funeral Service Lice see 23a. Part I. Enter the disease, of complications that caused the coath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listionly one gause on each line.

Immediate Cause (Final) en Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscienotic cardiovascular clisease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): for use as the IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Onknown 1 TYes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? and 24a. Was an adenocarcinomas hes autopsy performed this certificate 2 No 1 Tyes 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 2 No 1 Tyes 4 Nursing Home Certification; To 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl

To the Funarai Director:
completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

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2008

32. Registrar's Signature

Walther

Blud

08-05790

Kenneth David Raines

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 24839

			1- For State Registrar		Certific	ate of	Death			Re	g. No.		
F	Physicia		Decedent's Name (First, Middle,L	ast)					2	. Date of Death Month	Day Yea		. Time of Death
Medical	I Exami	ner	Kenneth	David Ra	aines					July 29, 20	08	·	0344 hrs
			4a. Facility Name (if not institution, g 3500 Golden Rod Lane	ive street and number)		4	b. City, Town, or Parkville	Location o	of Death		4c. County of Baltimor		ty
	uneral irector		220 20 2742		(In yrs. last bir		Months Days	_	_	8. Date of Birt	/1962	9. Birthr Foreign Coun	Maryland
	nector			X M 2 F	45	Yrs.		ij.		10/13	71302	Coun	try)
	- k	- 1	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town	or Locati	on					I	0d. Inside City Limits
7	show as	5	MD Baltir	nore	-	rkvi							1 Yes 2 X No
6	a the Maryland 3a or 28a-f she otified at once	Director	10e. Street and Number	J T			10f. Zip Code 2123	1		10	g. Citizen of Wh	nat Countr	y?
0	is 23a c e notif		3500 Golden Ro	12. Was Decedent	Ever in U.S.		s Decedent of His	panic Orig					n Indian, Black,
1206-1	', or item	Funeral	Never Married 2 Marri Widowed 4 Divorce	Armed Forces? 1 Yes 2 ed If Yes, Give Year	X No		es, specify Cuban Yes 2 X No		, Puerto R	tican, etc.)		e, etc. Whit	:e
-	urs ar tural amine	호	15. Decedent's Education (Specify	or Dates:	pleted) 16a.	Deceden	t's Usual Occupat	ion (Give I			16b. Kind of Bu		
21215-0036	2 should be tiled within 72 ho h and Mental Hygiene. 27 is marked other than "na matic event, the Medical Ex-	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	during mo aint	ost of working life.	. DO NOT	use retire	d)	Sub-C	ontr	ractor
0	ygier other	Ö	17. Father's Name (First, Middle, La	st)							Maiden Surname)	
215	uld be tilk Mental H marked c event,	Be (Raymond T. Ra	aines, Jr	•			Bet	tyLe	ee Cap	lan		
. 12	nd Mer is mar		19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing	Address (Stree	et and Num	nber or Ru	ral Route Num	ber, City or Tow	n, State, 2	Zip Code)
₽	th and the number of the the		Jonathan Raine	s/ Brothe			Whitt				•		
ē.	ages I and 2 nt of Health a t: If item 2 other traum		20a. Method of Disposition 1 Burial 2 X Cremation		20b. Place crema	of Dispos tory or oth S T U	ition (Name of cer per place) uneral Bel Ai	metery,		Date 31/08	20c. Location Fores	-	own, State
Baltimore,	permit, Page Department of Important: injury or oth		Donation 5 Other Special Service Lice		d	EV a	ame and Address ans Fune	of Facility	'Chaj	pel &	Çremat	ion	Services
	ysician	/	23. Part I. Enter the disease, or co	mplications that caused	the death. Do n	ot enter th	00 Harfo	such as c	ardiac or	Parkvi respiratory arre	St. shock, or he	art Z	Approximate Interval
	/ledical		failure. List only one cause on	each line.									Between Onset and Death
⊏x	aminer	8.1	Immediate Cause (Final disease or condition resulting in death)	a. Hanging Due to (or as a conse	equence of):	_		_	_			_	
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		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):								
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,160,	te be iysicii buria	/Medical	IF FEMALE:	23c. If yes, outcor							23d. Date of	f delivery	
876	titical ng ph as the	2	23b. Was decedent pregnant in the	1 Live birth			tal death 3	Ectopie	c pregnan	су	Month	-	y Year
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6	t the do by the ached I	Phy	Part II. Other significant condition		n but not resultir	na in the u	underlying cause	given in Pa	art I.	23e. Did to	bacco use cont	ribute to th	ne cause of death?
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isi	or Atteno after death Director: I in by the	fica	2 Accident Investig	28e Place of in			et, factory, office I	building, e	tc.	28f. Location (Street and Numb	er or Rura	al Route Number, City
<u> </u>	ital o urs afi ral D	er:	3 X Suicide 6 Could r 4 Homicide determine	ned (Specify) Si	ngle fa	mily	residen	ce	ļ	Parkvi.	Lle, MD	Сота	en kod Lan
	To the Ilospital or Attending Physician: The law requires that the death certificate be executed within 24 but as faced as within 24 but as a strength death of the strength and 10 the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical C	Chock only	ician: To the best of m									
	To To	Mec	29b. Signature and title of certifier	and manner stated.			29c. Licens	se number			29d. Date sign	ned (Mont	th, Day, Year)
			to l. M	0 Da.			o.c.	M.E.			July 29, 20	800	
	1		30. Name and address of person w	no completed cause of	r leath (Item 23a)								
	P		Tasha Greenberg MD.	Assistant Medic	al Examiner	111	Penn Street,	Baltimo	ore, MD	21201			
	S Regis	tate trar	31. Date filed (Month, Day, Year) AUG 0 1 2008	32. Registra	r's Signature	we)						

			For State	State of	Marylar	nd / Depa	artment d rtificate	of Hea	Ith and M	lental Hy	(2008	24840
			Registrar 1. Decedent's Name (First, Middle, La	not)		Cer	uncate	oi Dei	alli	2. Date of De	Reg. No.		3. Time of Death
	Physicia	an	LENA P	RICH BUI	D Ca					Month	Day	Year	0
	/Medic	100					4) O't To	1	ation of Dooth	·JULY	22	2008 ounty of Deatl	
	Examin	er	4a. Facility Name (If not institution, girl CRESCENT		iber)		**	vn, or loca	ation of Death			PINCE	GEORGES
	and a debate of the second			CITY Sex	7 Ago (In yre	last birthday)	If Under 1 Y		Jnder 24 Hrs.	8. Date of Bir			hplace (State or Foreign
	Funeral Director			1 □ M 2 X F	89 (m yrs.	Yrs.			ours Min.	(Month, Da	ıy, Year)	Col	untry)
C			Usual Residence of Decedent		09					August	21,19	18 GA	
	land ow at		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
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	r 28a	Director	10e. Street and Number	Jeorge J		Cinpac .	10f. Zip Co	de			10g. Citize	n of What Co	untry?
	3a ol		5103 Acorn Drive				2074	.8			USA		
	ms 2	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13.			nic Origin? (Sp	ecify Yes or No Rican, etc.)		. Race - Amei	
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5	within 72 hours after death with the Maryland ene. Than "hatural", or Items 23a or 28a-f show he Medical Examiner must be notifled at	þ	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Da	e ites:		1□ Yes 2🎇	INO SE	pecify:		S	pecify:	Black
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land	be filed within 72 hours after death with the Marylan at all Hygiene. and thy yiene natural", or Items 23a or 28a-1 show at event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, Las	•					_	e (First, Middle	, Maiden St	urname)	
<u>X</u>	should be and Menta marked umatic ev	ဥ	Frederick Dougla	s Lucas					Lola Is	sac			
Mar	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (S	treet and I	Number or Rur	al Route Numb	er, City or T	Town, State, Z	Zip Code)
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a	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Fullera Service Le	nsee		22	2. Name and A	Address of	Facility Man	shall's	s Fune	eral Ho	ome of MD
מ	B B E B		MIKON		.d R. G	ray 43	308 Su	itlan	d Road	Sui	tland,	, MD 2	20746
			23a. Farth. Enter the disease, of cor shock, or heart failure. List only	nplications that ca	aused the dea	th. Do not ent	ter the mode o	of dying, su	uch as cardiac	or respiratory a	ırrest,		Approximate Interval Between
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	ed fo	sici	in the past 12 months? 1 X Yes 2 ☐ No		ant at time of		Other (spec					Month	Day Year
r Ö	at the by the	hy	9 ☐ Unknown							1			
က် က	res that the death certificing of the attending of the detached for use as	by I	Part II. Other significant conditions	_		sulting in the u	nderlying caus	se given in	Part I.			_	the cause of death?
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Kecords		Completed	PULMONARY	HEPERT	ENTION	·				24a. Was	an Insv	24b. Were au	utopsy findings available completion of cause of
	The law ate has be page 2 sh	E O								perf	ormed?	death?	2 No
Vital		Be C	25. Was case referred to medical					26.	. Place of Deat	h (Check only			
	Physician: this certific ral director,	To E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🔲 I	npatient 2	☐ ER/Outpatier	nt 3 DOA	Other:	Nursing He	me 5 Res	idence 6	□Other (Spe	cify)
יסר	ng PP ter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of	of Injury th, Day Year)	28b. Time o Injury	of 28c	. Injury at Work?		28d. Describe			
<u></u>	ttending P death. stor: After t	atio	2 ☐ Accident investigation	on	,,		M		2 □ No				
Division	ar de	iţi	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	Zoe. Flace	of injury - At I	nome, farm, str	reet, factory, o	ffice		28f. Location ((Street and wn, State)	Number or Ru	ural Route Number,
ב	tal or	Certification:			3, 1,								
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying F	hysician: To the aminer: On the ba	best of my kr	owledge, deat	th occurred at	the time, o	date and place	and due to the	cause(s) a	ind manner as	s stated.
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	To To Com	Σ	29b. Signature and little of certifier					icense nu				signed (Mont	
	ı		Isla Vibr	- n.D.)-25	914		7	-23-0	18
-	5		30. Name and address of person who	completed caus		m 23a) (Type,	Print)			Δ			
	2		ALLEN BRIMI				ST-WES	HIG	HWAY,	RIVERD.	ALE, P	1 ARYLA	UPAN
1	Sta		31. Date filed (Month, Day, Year) AUG 0 1 2	008 33 A	egistrar's Sigr	nature			,				
	Registr	air	WOR O T F	JULY JULY	COMB D 1	Ch Fin	ELANDA A						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene.

			For State Registrar	State of Marylant	-	rtificate of			Reg. N	/HHX	24841
			1. Decedent's Name (First, Middle, La.	st)				2. Date of De	eath	ay Year	3. Time of Death
	Physici /Medio		ROSCOE STANLEY	ROBERTSON				JULY	26	2008	1440 ^M
	Examin		4a. Facility Name (If not institution, giv				Location of Death		1	c. County of Death	
	en a more		2107 RAMBLEWOOD I 5. Social Security Number 6. S		act hirthday)		T HEIGHTS If Under 24 Hrs.	8. Date of Bir		PRINCE GE	
	uneral rector			M 2□F 54	Yrs.	Months Days	Hours Min.	JUNE 2	ay, Yea		place (State or Foreign ntry)
land	It ow		10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
Mary	-f she	ţo	MD PRINCE (GEORGE'S RIV	ERDAL	E					1X Yes 2 □ No
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ath wi	23a d	Funeral Director	6209 LONGFELLOW S	TREET		20737				SA	
er des	items ner m	nue	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ameri Black, White	
C Z IZ IS-UUSO filed within 72 hours after death with the Maryland Hygiene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, <u>the Medical Examiner must be notified at once.</u>	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2 K No	Specify:			Specify: BL.	ACK
2-6 72 hou	natura Jical E	Completed	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup	ation during most of work	ina	16b.	Kind of Business/Ir	ndustry
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ied w Hygie	nt, th		17. Father's Name (First, Middle, Last	1 YR	FORK	LIFT OPER	ATUK 18. Mother's Nam	e (First Middle	1	IONAL GE	JGRAPHIC
and d be file ental Hy	ed of	o Be	REMANA DAVIS	,			GRACE M		, maio	on Cumame,	
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nd 2	27 Is er trau		JACQUELINE D. DAV	/IS / SISTER	2666	HORSE HO	RN ROAD	RED	OAK	, VA 23	964
es 1 a of Hee	f item r oth	8	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	lace of Dispo emetery, cre	osition (Name of matory or other place	ce)	Date	20c.	Location - City or T	own, State
Pages ment of h	ant: I	9	4 Donation 5 Other (Special	(y) Sal		tist Ch.	J C III .	2-2008		D OAK, V	
baltimor bermit. Pages Department of	mport iny ln		21. Signature of Funeral Service Lice		1		ss of Facility MA LAND ROAL				OME OF MD 20746
- 40	_ (0 U)		23a Part Enter the disease or com	DONALD R. GR	uri					AND, PID	Approximate
Dha	-1-1		23a. Part 1 Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final				ig, odom do odraido	or roopiratory t	arroot,		Interval Between Onset and Death
	sician edical		disease or condition resulting in death)	a. Cardiac Arr		1a					
Exa	miner			b	,						
, D	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease or injury	Due to (or as a consequ	ence of):						
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5875U , rificate be executed	physician and s the burial-transit			Due to (or as a consequ	ience or).						
00/ ficate	g phys as the	ledical		▲d							
× ē	ending use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal		⊒Ectopic pregnanc				23d. Date of deli	•
. e	he att	sician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de		Other (specify)				Month	Day Year
r the S	d by t letach	Phy	9 ☐ Unknown Part II. Other significant conditions	contributing to death but not resu	ulting in the u	ınderlying cause giv	ren in Part I	23e Did	tobacco	use contribute to	the cause of death?
ecords, P.O	certificate has been signed by the attendin rector, page 2 should be detached for use	d by	Chronic Obstruct			, , ,	on an acti.				bably 4 🕅 Unknown
ecor law req	shoul	lete						24a. Was	s an	24h Were au	topsy findings available
Ľ 22	te has age 2	Completed						auto perf	opsy formed?	prior to c death?	ompletion of cause of
	rtifica tor, p	a)	25. Was case referred to medical			99	26. Place of Deal	1 Yes th (Check only		No ILI Yes	2 No
Or VITA Physician:	his ce direc	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	0		ome 5□Res	sidence	6 Dother (See	rlfriend's
	After this funeral di		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe	how in	jury occurred	110 000
UIVISION I or Attending after death.	the f	cati	2 Accident investigation 3 Suicide 6 Could not be	e 290 Place of injury. At he	me farm et		Yes 2 □No	29f Logation	(Stroot	and Number or Ru	ral Dauta Number
lor A	Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specify	()	ioci, idoloi y, omoo		City or To			rai moute wamber,
ospita hours	uneral y fille	a C	29a. Certifier 1 Certifying P	hysician: To the best of my kno miner: On the basis of examina	wledge, dea	th occurred at the ti	me, date and place	, and due to the	e cause	(s) and manner as	stated.
DIVISION To the Hospital or Attending within 24 hours after death.	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one)	miner: On the basis of examina and manner stated.	uon and/or i			rred at the time	e, date a	and place, and due	to the cause(s)
To 1	6	Σ	29b. Signature and title of confiner			29c. Licens				Date signed (Month	
)	0			MD MD		D570	028		Jt	uly 30, 2	.008
	D		30. Name and address of person who ADITYA CHOPRA	completed cause of death (Item 600 RIDGELY AVI			APOLIS, M	D 2140	1		
	Sta	ate	31. Date filed (Month, Day, Year)				TOPIS, III	2140	T		
	Regist		AUG 0 1 2008	Jacobs St.	ture						

State Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland	-	artment of F ctificate of a		-	giene Reg. No	2008	24842
	Physic	ian	1. Decedent's Name (First, Middle, Las					2. Date of De	Da	ay Year 2008	3. Time of Death
1	/Medi Exami		Margaret Naomi R 4a. Facility Name (If not institution, give	**		4b. City, Town, or	r Location of Death	July 2		c. County of Deat	12:52 A.M
	Funeral Director	33	Carroll Hospital 5. Social Security Number 6. Social 166-12-4264			Westmins If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ıy, Year) Co	nplace (State or Foreign untry) nsylvania
	70		Usual Residence of Decedent					our: I		320 2 0111	
	show show	2	10a. State 10b. County		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2\hat{VNo}
	the N 28a-f	rect	Maryland Carroll 10e. Street and Number	Mand	cheste	10f. Zip Code			10g Ci	itizen of What Co	
	h with	Ö	4334 Rupp Road			2110	2		Uni	ted Stat America	es
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes ②XXNo If Yes, Give Year or Dates:	'		lispanic Origin? (Spi an, Mexican, Puerto Specify:			14. Race - Amer Black, White Specify: White	e, etc.
5-0	72 ho 'natur dical	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Deced	lent's Usual Occup	ation during most of work	ina	16b. k	Kind of Business/I	ndustry
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d 2	12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "n traumatic event, the Medl	ပ္ပိ	12th 17. Father's Name (<i>First, Middle, Last</i>)		HOM	emaker_	18. Mother's Name	e (First, Middle	. Maidei	Own Hom	e
lan	ld be lental ked o	To Be	John H. Miller				Linnie				
ary	shou and N s mar	-	19a. Informant's Name/Relationship (7	ype. Print)	19b. Mailin	g Address (Street	and Number or Rur		er, City	or Town, State, Z	lip Code)
	and and and m 27 I		Esther N. Renoll								ter, MD 2110
Baltimore,	Pages 1		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □	Hemovai from State		sition (Name of natory or other plac	riugu	st 2,		ocation - City or	
Ħ	artme ortani Injury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			Cemetery Name and Addre	ss of Facility		Line	eboro, M	aryland
B	Depared Important Important Information In		Xam Momental	1/2.	EC 32	khardt Fi 96 Charm:	ss of Facility uneral Ch il Drive,	apel, P Manche	.A. ster	r. Marvl	and 21102
i,	Physician		23a Part Enter the disease, or composition of heart failure. List only of limited are cause (Final disease or condition			er the mode of dyir				, , , , , ,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequent							
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68760,	ficate be executed physician and sthe burial-transit	edical Exar	that initiated events resulting in death) Last	C	ence of):						
O. Box	law requires that the death certifica as been signed by the attending pf 2 should be detached for use as tf	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	Ectopic pregnancy Other (specify)	,			23d. Date of deli Month	very Day Year
S, P.	w requires that s been signed b should be deta	by Pł	Part II. Other significant conditions co	ontributing to death but not resul	ting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
ord	requir sen si rould b	ted						1 🗆 '	Yes 3	No 3□ Pro	obably 4 Unknown
al Records,	The ate has page	Completed						24a. Was autoj perfo 1 Yes		prior to death?	topsy findings available completion of cause of 201 No
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O	≥ .º o	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	R/Outpatien 28b. Time of	I SLI DUA	4 LI Nursing Ho	me 5 Resident		6 □Other (Spec	cify)
ion	Attending F r death. ector: After by the funers	atior	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	lnjury		k? Yes 2 □ No		,	,	
Division	in Pite	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tox			ral Route Number,
	To the Hospital within 24 hours a To the Funeral scompletely filled	Medical (29a. Certifier (Check only one) Certifying Phy 2 Medical Example	ysician: To the best of my know iner: On the basis of examinati and manner stated.	ledge, death on and/or inv	occurred at the tir restigation, in my o	me, date and place, ppinion, death occur	and due to the red at the time,	cause(s date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To t To t	Ž	29b. Signature and title of certified	C. Nay	m-0	29c. Licenson	e number		29d. Da	ate signed (Month	n, Day, Year)
1			30. Name and address of person who of			Print)				-	
Ĭ	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signat		WA POO	LERDU	VESTMI.	NSIT	R M1.) 21151)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend PII, 25, perME G882 8/16/08/iffrate of Death

Reg. No. 2 Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** : 37 PM ances /Medical 4a. Facility Name (If not institution, give street and number) c. County of Death 4b, City, Town, or Location of Death Examiner Middle Kive Itai 9. Birthplace (State or Foreign Country) Tome If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days 1□M 2**X**F Months Director Marylan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hygiene. Inmortant: If item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, Ite Medical Evantime must be notified. and once. Director more 10f. Zip Code 10e. Street and Number 10g Citizen of What Country? SH aa Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Rout) Number, City or Town, State, Zir Code) Essex Almond 1 20b. Place of Disposition (Name of cemetery, crematory or other place)

22. Name and A dress of Facility

22. Name and A dress of Facility Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3 orest Hill 21. Signature of Fineral Service Licensee natives Funeral + Cremation Ctr.P.A. Timonium mo 21093 YOUK I'd 23a. Part 1. Enter the disease, or compiler tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician pheumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pization Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Dementio physician and CERTIFIC Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the y the attending pl ched for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknoy ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OiN 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an has page 2 s autopsy this certificate 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 4 Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide t > ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier **Medical** (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D006a194

State Registrar

STUDZINSK

timore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Desai

a.D

32. Registrar's Signature

hintan

1 2008

31. Date filed (Month, Day, Year)

AUG 0

State of Maryland / Department of Health and Mental Hygiene 24844 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) George Edwin Smith JE 2. Date of Death 0647 AM **Physician** a Year FORSE DWILL JU/4 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Year) 1**X** M 2 □ F Yrs. 034 20 138 30 Director 7320HJAZZA 31 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f slist be notified 1 ☐ Yes 2 No Director JARYLAND HARFOR 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? -5 -Funeral 200 15 V IR 21014 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Armed Porces:

1 Ves 2 No
If Yes, Give
Year or Dates: iled within 72 hours after 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Me Elementary/Secondary (0-12) College (1-4 or 5+) other then 163 2577 MAIOR BUTHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental 27 Is merked of treumetic ever ZUROIC ARNAR Pages 1 and 2 should nent of Health and Men မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CHTOROL 1 R 13 VERGOOT ana, if item 27 AID IL other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation
4 Donation 5 Other (S 3 Removal from State ò Department of Important: If any Injury or once. 5 Other (Specify) BOSE ELE LIVE FORUST 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
EVACUE FOR DRIVE
3 12W PORT DRIVE HEREL-ERVENTION SIR 1-5825T 201E 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY **Physician** DAY /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, by Physician/Medical attending | IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal dea ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform ate has page 2 2 □ No 2 No 1 Yes 1 Yes Division of Vital Attending Physician: 25. Was case referred to medical Was case examiner?
Yes 2 No director, Be 26. Place of Death (Check only one) Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 2 Accident 5 Pending investigation death. 1 Tes 2 🗌 No after deatl 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò To the Hospital or within 24 hours aft To the Funerel Dis completely filled in **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Scott MARSHAW, THE TOWNS HOPKINS HOSPHAL. 600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible, Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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2008

Sparke)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month July Day 2008 **Physician** 30, 5:30 ΑM Margaret Rosalie Scharf /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Riverview Care Center Essex If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 10/05/1937 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Maryland Min. 1 □ M 2 🕅 F 70 217-34-7623 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Madical Examinar must be notified at Middle River 1 ☐ Yes 2 K No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2835 Eastern Blvd., Apt.#2 21220 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 DNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2XNo Specify. Specify: δ. White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than "I Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: if item 27 is marked other the any lulury or other traumatic event, ITED 10 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Thomas Pretty Ruth Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Gelhard (Daughter-in-law) 3926 Tidewood Road, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ₩Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 08/01/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Fugeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part is buter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 monte **Physician** SICI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed and Due to (or as a consequence of): burialphysician a Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.0. the 9 Unknown signed by t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has page 2 s autopsy performed? Yes 2 No certificate 1 □ Yes To the Hospital or Attending Physician: within 24 hours. fler death.

To the Funeral Unrector: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei (Check only one) 29c. License number # 3 \$ 5 9 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who complete

-01

Mace Ave, Baltimore,

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2008 **Physician** 27, JULY 5:50A M EVA MAE SMITH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S MAGNOLIA CENTER LANHAM If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 🛛 F Yrs SC 21, 1918 Director 240-36-4993 JAN. 90 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Show notified at 1XYes 2 No Director PRINCE GEORGE'S MITCHELLVILLE MD28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 8 23a 20721 USA 12204 KINGSWELL STREET Examiner must Funeral items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. after 1 ☐ Yes 2 No If Yes, Gîve Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No Specify. Specify: þ BLACK 3 Widowed 4 Divorced Completed Medi a 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Hyglene. College (1-4or 5+) Elementary/Secondary (0-12) the Domestic Worker Private 6th h and Mental Hygler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be be Celina Trusdale Walter Hammond 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Mitchellville, MD 20721 12204 Kingswell Street Robert Lee Blackmon / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 07-31-2008 | Landover, MD 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 21. Signature of Funeral Service 20746 SUITLAND, MD DONALD R. GRAY 4308 SUITLAND ROAD lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or of shoots or heart failure. List on Immediate Cause (Final Physician Weeks disease or condition resulting in death) Pneumonia, Aspiration /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 No ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Dementia, Stroke page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2K No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2♥ No 2 ER/Outpatient 3 DOA ဂ 1 Inpatient To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homîcide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 28, 2008 D32261 30. Name and address of person who c pleted cause of death (Item 23a) (Type, Print) 9500 ANNAPOLIS ROAD SUITE A4, LANHAM, MD 20706 RICHARD FELDMAN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 1 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 30 2008 Year **Physician** 1:49 P M Helen Mildred Shields /Medical 4b. City, Town, or Location of Death Towson 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number)
Gilchrist Hospice Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign November 25 1927 Baltimore, Maryland 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 □ F 217 24 5367 80 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Modical Examinar must be notified at 1 □Yes 2V□No Maryland Baltimore Edgemere Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21219 USA 7715 Bay Front Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🏿 No 11. Marital Status 1 ☐ Never Married 2 Married 1 □ Yes 2 No Maryland 21215-0036 Specify. If Yes, Give Year or Dates: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (NAS+) 2 should be filed within and Mental Hygiene. Housekeeping-Own Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Joseph Volz Mary Alice Durham ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgemere, Md. 21219 permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is 7715 Bay Front Road Walter E Shields (Husband) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Metro Crematory Inc July 31 2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Lassahn Funeral Home Inc. 0 XH 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrost, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY ARTERY **Physician** YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician certificate be Physician/Medical the as IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes No 3 🗆 Ectopic pregnancy for Month 5 Other (specify) icate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Volo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certification July 30, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NOMAPLES ST, SHITE 209 CALTIMORE, MD 21204 DANIEUR DOBLEMAN. MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 AUG 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1_ Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Stubar ranko 6:28pm /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death County of Death Examiner Harring Ton Drive Slamac Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1X M 2 □ F 24, Director 185-12-7094 85 1922 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Everative must be notified at 1 ☐ Yes 2 1 No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9115 Harrington Drive 20854 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 1 No Specify. þ Specify 3 Widowed 4 Divorced WW II White Completed or than "natura 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Attorney Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Mile Stupar Anna Dubinsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen A. Stuper / Wife 9115 Harrington Drive Potomac, Maryland 20854 Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Sept. 19,2008 Arlington, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.
Robert A. Pumphrey Funeral Home/ Rockville, Inc
300 W. Montgomery Ave. Rockville, MD 20850-2805 M00896 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cute . Physician renal day /Medical Due to (or as a consequence of): Examiner hydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Co. or Attending Physician: The law requires that the death certificate be executed after death. Pancicalic that initiated events resulting in death) Last by Physician/Medical attending p IF FFMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Nove 2 No 3 ☐ Probably 4 ☐ Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed! Yes 2 No 2 No 1 ☐ Yes 1 ∏Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home Residence 6 Other (Specify) this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Injury M 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hou To the Fune completely file 29a. Certifiei Medical 29d. Date signed (Month, Day, Year) 29b. \$ignature and tive of certifier 29c. License number 2 Medical Doctor D67 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) National 10 Center *lebanoff* Christophe 32. Registrar's Signature 31. Date filed (Month, Day, oach. Year) State 0 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July2008 David Troy Tolbert 8:48 A M 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Min. Hours 1**X** M 2□ F 224-20-1817 84 Virginia October 6, 1923 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1116 Agnew Drive 20851 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2X Married Specify: White 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Furniture Sales/Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Jarnett Tolbert Iowa Mabry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Tolbert/ Wife 1116 Agnew Drive, Rockville, Maryland 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park August 4 Donation 5 Dother (Specify) Rockville, Maryland M01360 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a acteriosclerate collionasculos alsease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 robably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 100 24a. Was an autopsy perform 1 ☐ Yes 2⊞No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, the Modical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

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/Medical

10a. State

Directo

Funeral

2

Be Completed

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Exami attending physician and for use as the burial-trar Physician/Medical certificate has been signed by the rector, page 2 should be detached Be Completed by Medical Certification: To

1 Yes 2 ₹No

5 Pending investigation

6 ☐ Could not be

27. Manner of Death

1 Naturai

2 Accident 3 Suicide

4 Homicide

31. Date filed (Month, Day, Year)

29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

To the Hospital of within 24 hours aft To the Funeral Discompletely filled in State

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Person of Company, M. D. School Company, M. D.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day, Year)

and manner stated

32. Registrar's Signature

29b. Signature and title of certifier Yevgenry Gradesuan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #25 per ME 9881 7/25/08 TT
State of Maryland 7 Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Walter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

April 23,1957

B. Birthplace (State or F. Country)

Maryland Birthplace (State or Foreign Country) 5. Social Security Number 217-48-8-68 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M **X**X F Months Days Hours Min. 51 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ratural", or items 23a or 28a-f show any highly or other traumatic event, it is defected. 1 ☐ YesX2X No Director MD Baltimore Reisterstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21136 U.S.A. 4240 Piney Grove Rd. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1
Yes XXN
No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes XX No Specify. White 3 Widowed 400 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Post Office Post Mistress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be L. Lurlie Wilhelm Ralph Bennet Walter, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda L. Martin / Sister 16016 Trenton Rd. Upperco, MD. 21155 20a. Method of Disposition
1 □ Burial

X ☐ Cremation 3 □ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. 7/23/08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fur eral Service Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, MD 21102 /mmi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician hemorr Tracheal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Irachea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed physician and the burial-transit Intubation Due to (or as a consequence of): Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year P.0. ed by the a detached f g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2□No 24a. Was an this certificate has ral director, page 2: autopsy performed 2. No 25. Was case referred to medical examiner?

1 Yes Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number lence 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) US M.D. 32 Registrar's Signature old Court 31. Date filed (Month, Day, Year) State JUL 25 Registrar

	Am	end	Please I PI, 25,27,28a-f,	Type or Prin	t in E	Black J /25/0	ndelible ink B TT partment of h	. Ensure Al	II Copies Iental Hv	Are aien	Legible.	
			1 - For State Registrar	Otato of mo	a y lari		ertificate of			Reg. No	2008	24851
			Decedent's Name (First, Middle, L.	ast)					2. Date of De	_	2000	3. Time of Death
	Physici /Medi		THOMAS HAD	LOLD WAL	LAC	E			Twin	5	2008	7:20 A. M.
	Examir		4a. Facility Name (If not institution, g				-0	r Location of Death	9		. County of Death	
1			BALTIMORE WAS					If Under 24 Hrs.			MNEA	
	Funeral Director		5. Social Security Number 6. 219-34-0630	Sex 7. Age	(In yrs. I	last birthday Yrs.	Months Days	Hours Min	8. Date of Bir (Month, Da FEBRUDI)	ay, Year	9. Birtin	place (State or Foreign intry)
			Usual Residence of Decedent		01				172,000	-113,	1131 114	10.04.03
	with the Maryland ta or 28a-f show the notified at	_	10a. State 10b. County			y, Town or l						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he Ma 28a-f	ecto	10e. Street and Number	SUNDEL	al	ED R	3URNIE 10f. Zip Code			100.0	itizen of What Cou	
	th with 23a or	Ö	426 LINCOLN	DRIVE			210	160		rog. O	1 × A	шо у :
. 1	items 23	nera	11. Marital Status	12. Was Decedent E	ver in U.	S. 13	3. Was Decedent of H		ecify Yes or No)-	14. Race - Amer	
ي لا	or ite	Fu.	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ▼Yes 2 N If Yes, Give	lo		1 ☐ Yes 2 ☐ No		Hican, etc.)		Black, White,	
200	within 72 hours after iene. than "natural", or ite	d b	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:							ALEX-EV.	HITE
35	n 72 n "nat	Sete	15. Decedent's E (Specify only highest g	rade completed)		(Giv	cedent's Usual Occup re kind of work done . DO NOT use retired	during most of work	ing	160. r	Kind of Business/fr	ndustry
Mallak 21215-0036	ges 1 and 2 should be filed within tof Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, I'm M	Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4or 5-	+)		PECTOR	-,		Ro	AL COM	MOISSIMI
	al Hygie	Be C	17. Father's Name (First, Middle, Las	t)				18. Mother's Name	e (First, Middle,	, Maidei	n Surname)	
多量	hould be to the Mental marked o matic eve	၉	JAMES WA			1					EBSTA	
Zar Z	12 sho h and 7 is ma trauma		19a. Informant's Name/Relationship	A	7	1 .	iling Address <i>(Street</i>					
e 2	1 and Healt em 2		STEVEN WALLACE 20a. Method of Disposition	- / ISICUINIS			position (Name of ematory or other place		Date		ocation - City or T	
Thomas Baltimore, Maryland	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State			ematory or other plac くいげる ひとし		-9 Arz	ы	VINITI	NAN
alti i	+ E E E		21. Signature of Funeral Service Lice		11770;		22. Name and Addre	ss of Facility		LI	400000	100,2
<u>~</u>	Depa Impo any Ir					1.5	יא אייסדינית בלבל	refres pa	STE	D +	LANDULUR	NO 31076
		5	23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused y one cause on each line	the death	n. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician	0 10	Immediate Cause (Final disease or condition resulting in death)	a 57Mp	dir	5/	hemate	mt	-1.1	//		Onset and Death
	/Medical Examiner		recurring in death)	Tue to (or as a	consequ	uence of):	, and the second pro-	OFFITE CATION APPR	1 1/2	L EXAM!	NEF	() (
		ē	Sequentially list conditions, if any, leganing to infinediate	b. — Due to (or as a	ounsequ	iunce ut):		AN.	OVED O MEDIO			
	oe executed sian and urial-transit	Examiner	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c				-DTIFICATION APP.				
60,	oe exe cian a urial-1	-	resulting in death) Last	Due to (or as a	a consequ	uence of):		OSK.				
F 687	certificate be executed adding physician and ise as the burial-transit	Physician/Medica		d								
2 ×	leath certific attending p	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. Date of deliv	verv
, W	death e atte d for I	icia	in the past 12 months?	1 ☐ Live birth : 4 ☐ Pregnant at			□ Ectopic pregnand □ Other (specify) _	;y 			Month	Day Year
10°	at the by th	hys	9 🗆 Unknown	9 ☐ Unknown					· ·			
, v	ding Physician: The law requires that the de h. After this certificate has been signed by the funeral director, page 2 should be detached	þ	Part II. Other significant conditions	contributing to death bu	t not resu	ılting in the	underlying cause giv	en in Part I.			15	the cause of death?
30	requi	eted	Taperjon	1 Apodes	٧.	01/7	→ ~		1 🗆			bably 4 Dunknown
Rec	The law ate has b	Completed	<i>J</i>	Modes	In	e uu	M		24a. Was autor		24b. Were aut prior to o death?	opsy findings available ompletion of cause of
<u> </u>	ifficate or, pag		25. Was case referred to medical					00 Di 4 D4	1 □ Yes	2 QN	o 1 ☐Yes	2 🗆 No
Ş	Physician: r this certific ral director, I	To Be	examiner?	Hospital: 1 Inpatier	nt 2 🗆	ER/Outpation	ent 3 DOA Oth	26. Place of Deatler: 4 ☐ Nursing Ho			6 ☐ Other (Spec	if _V)
0	ng Ph fter th neral	J:UC	27. Manner of Dea h	28a. Date of Injur (Month, Day	v	28b. Time Injury	of 28c. Injur	ry at	28d. Describe			
siol	Attending I ar death. ector: After by the funer	catic	Thatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	n Fnd 7/7/0	8 F	Nd un	ık Å ¹□	Yes XXNo	probab			
Division of Vital Reco	l or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	building, etc.	ry - At ho . <i>(Specif</i> y	me, farm, s	treet, factory, office		28f. Location (S City or To	Street a wn, Stat	nd Number or Rui	26 Lincoln
	Hospital 24 hours a Funeral I		29a. Certifier 18 Certifying F	Physician: To the best o		home					urnie, M	
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical	(Check only Medical Exa	miner: On the basis of and manner stat	examinat	tion and/or	investigation, in my o	opinion, death occur	red at the time,	date ar	nd place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Da	ate signed (Month	, Day, Year)
	101		data	M	7		DP	3977		Den	m 8 2	2008
	ľ		30. Name and address of person who	completed cause of de	ath (Item	23a) Type	Print) DO	e, alen	anna !	ò	2 aug	1061
	Sta	te	31. Date filed (Month: Pay, year)	32 Registra	r's Signa	ure 777	· OLOVY	-1 chun	a IVITO		1100 2	1001,
	Registr		OUL 4 J Z	UU Chis	1 /	X A	osole					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** NISE BOOK /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE exa HVENUE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1□ M 21 F Yrs. **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. Count 10c. City, Town or Location State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Specify: White 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: b 3 Widowed 4 ☐ Divorced of Health and Mental Hygiene. Item 27 is marked other than "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) home 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) be f Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) 20c. Location 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, mo 21. School en uner School ens e Cichation 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lay minHi Physician disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physiciar Physician/Medical as the IF FEMALE nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregpant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mor for Month Dav Year Pregnant at time of death 5 Other (specify) P.0. to the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached 9 I Inknown 23e. Did tobacco use confibute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only the) Other: 4 \sum Nursing Home Hospital: 2 NONC 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) 1 Tes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) AUG 0 1 2008

Jchneder

32 Registrar's Signature

			For State Registrar	State of Mar	yland /	Certificate			Reg. N		24853
	Physicia	an	Decedent's Name (First, Middle, L.					2. Date of D Month JULY		^{2ay} , 2008	3. Time of Death 12:30 A M
	/Medic	al	Robert Pratt Wine 4a. Facility Name (If not institution, g			4h City To	wn, or Location of De			c. County of Death	
	Examin	er	GREATER BALTIMO		CENTE					BALTIMO	
	Funeral Director		5. Social Security Number 6. 212-50-3016	Sex 7. Age (in yrs. last 61	birthday) If Under 1	Year If Under 24 H Days Hours M		irth Pay, Yea 19	9. Birth Cou Mary	pplace (State or Foreign intry) Pland
O	and w		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, To	own or Location		<u> </u>			10d. Inside City Limits
1	ith the Marylar or 28a-f show e notified at	lor		ore County	Coc	keysville					1 ∐Yes 2ÀŠ No
1	r 28a- notif	Funeral Director	10e. Street and Number			10f. Zip C	ode	-	10g. C	Citizen of What Cou	untry?
22	th with	al D	10704 West Castle	9			21230		Uı	nited Sta	ites
w	ems er mu	ıner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Deceder If Yes, specif	nt of Hispanic Origin? / Cuban, Mexican, Pu	(Specify Yes or Nuerto Rican, etc.)	lo-	14. Race - Amer Black, White	
GARD, ROBE Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Heatth and Mental Hygiene. It of Heatth and Mental Hygiene. If tiem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 Widowed 4 Divorced	1 ☐ Yes ②☑️No If Yes, Give Year or Dates:			XNo Specify:			Specify: V	hite
2505	72 hc 'natur	To Be Completed by	15. Decedent's (Specify only highest of	Education grade completed)	1	6a. Decedent's Usual (Give kind of work life. DO NOT use	Occupation done during most of the state of	working	16b.	Kind of Business/I	ndustry
121	within iene. than "	Idm	Elementary/Secondary (0-12)	College (1-4or 5+) 05			itecht			Underwoo	od Pratt
0,2	filed v Hygid Sther	S C	17. Father's Name (First, Middle, La				18. Mother's N	Name (First, Middi	e, Maid	en Surname)	
E S	lid be lental rked c	o B	Robert A. Wingard	£			Elizak	oeth Wilk	ins		
ary Tr	shou and N s mai		19a. Informant's Name/Relationship		į	9b. Mailing Address (S					ip Code)
1GARD, B, Maryland 2	and 2 ealth m 27 I		Mr. Robert Russo	(Friend)		5903 Hicko	-	Stewart		wn,PA. 1	.7363
NIN ATN	permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: if item 27 is marked other tha any Injury or other traumatic event, the		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	Evan	e of Disposition (Name etery, crematory or oth S Funeral		og.02, 2008	Fo	rest Hill	,Maryland
Ball	permit Depar Impor any In	3 4	21. Signature of Funeral Service Lie	1	far	2325	1 d Aiternat York Road	ives Fur Timor	era iiun	l&Cremati ,Maryland	on Ctr.,P.A 21093
			23a. Party Enter the disease, or co shock, or heart failure. List or	omplications that caused in	ne death. D	o not enter the mode	of dying, such as care	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as a c	consequen	ce of):	Farch	0			
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B	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as a	consequen	ce of):					
799289	icate by physical the bu	edical		d							
	certific ding p	/Me	IF FEMALE:	23c. If yes, outcome pf	f pregnancy	,				23d. Date of del	iverv
O. Box	To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live birth 2 4 ☐Pregnant at tii 9 ☐ Unknown	☐ Fetal de	ath 3 ☐ Ectopic pre	gnancy cify)			Month	Day Year
P.0	w requires that the debeen signed by the should be detached	by Ph	Part II. Other significant condition	s contributing to death but	not resultin	g in the underlying cau	ıse given in Part I.	23e. Die	d tobacc	o use contribute to	the cause of death?
ş	equire en sig ould b	ed b	une co	incer				_ 1[Yes	2 No 3 Pr	obably 4 🖾 nknown
900	e law re has be	Completed	PANCYK	penia				24a. Wa	tonsv	prior to o	topsy findings available completion of cause of
- E	The cate har page	Com	renal w	rsusticie	MC	4		pe 1□ Yes	rformed 2	2 death? No 1 ☐ Yes	_/
\ Kits	ysiclan: This certificate	Be	25. Was case referred to medical examiner?	Hospital:		<i>'</i>	Other:	Death (Check onl			
٥	Phys r this ral dir	<u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manper of Death	28a. Date of Injury	28	Outpatient 3 DOA	d	-		e 6 □Other (Spenjury occurred	cify)
o u	nding Ph th. : After th e funeral	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day)	Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No				
Division or Vital Records.	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft.	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Place of injury building, etc.	y - At home (Specify)	, farm, street, factory,	office	28f. Location City or 1	(Street own, St	and Number or Ru tate)	ural Route Number,
	pital o urs aft eral D		On Codifier 17 Codifium	Physician: To the best of	my knawla	dae deeth accurred e	t the time date and n	lace, and due to t	no cause	o/s) and manner as	stated
	24 ho 24 ho Fun etely f	Medical		xaminer: On the basis of e	examination						
	Fo the within Fo the somple	Me	29b. Signature and title of certifier				License number	_		Date signed (Mont	
			Cuutura	Swan	~ L	w I	1005134	7		7/30/0	8
	8		30. Name and address of person w	ho completed cause of dea	ath (Item 23 6701	N. Charl	esst. Ba	istimo	18	MD 212	evy
		ate	31. Date filed (Month, Day, Year)	//32, Registrar	's Signatur	Park.					
	Regist	rar	AUG 0 1 200	10 Resilve.	for 1	STORES S					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24854 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Month Day 3:15 AM emue 30 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 056-18-7468 84 Director 04/26/1924 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Inc. Provice Examiner inst by profilied at Director 1 ☐ Yes 2 No MONTGOMERY MD SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3310 N. LEISURE WORLD BLVD., Funeral 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. be filed within 72 hours after 1 ☐ Never Married 2 🕅 Married 1 □Yes 2 X No 2 Specify: WHITE Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) U.S. CUSTOMS INSPECTOR DEPARTMENT OF TREASURY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES Pages 1 and 2 should I WILLS RUTH ၉ YARBROUGH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 is
any Injury or other trai
once. ROSLYN WILLS / WIFE 3310 N. LEISURE WORLD BLVD., #515, SILVER SPRING, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
MEMORIAL GARDENS 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/01/2008 OLNEY, MD 21. Signature of Funeral Service Licenses 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. Mest 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tastrointestin /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-trar Due to (or as a consequence of): the attending physician Physician/Medical the as IF FEMALE: use If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Į in the past 12 months?
1 Yes 2 No Month Year Dav 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: After 28d. Describe how injury occurred 5 ☐ Pending investigation 1-Natural hours after death, uneral Director: A 2 Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be exect Division of Vital Records, P.O. Box 68760 n 24 hou. the Funeral Dire To the Hosp within 24 ho To the Fune completely f

Baltimore, Maryland 21215-0036

5

State Registrar

29b. Signature and title of certifier

450 31. Date filed (Month, Day, Year) Montgomeri

32. Registrar's Signature

29d. Date signed (Month, Day, Year) 30-08

Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** Vear **GREGORY** WATSON WRIGHT /Medical JULY 26 2008 0025 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Chaverl 1405 rince If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) (In vrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1XM 2□ F Director 579-86-5686 45 SEPT 4. 1962 DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Director 1 X Yes 2 □ No MD PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 900 ST. MICHAELS DRIVE 20721 USA by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1XYes 2 No 1984 If Yes, Give Year or Dates TO 1986 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LINEMAN SUPERVISOR VERIZON Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE WILLIAM WRIGHT EDNA MAE WATSON or other traumatic ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is JEFFREY WILLIAM WRIGHT/BROTHER 11013 JOHN PAUL JONES AVE FT WASHINGTON, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHELTENHAM VETERANS CHELTENHAM, MD injury 08-08-2008 21. Signature of Rune al Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD DONALD R. GRAY 4308 SUITLAND ROAD SUITLAND, 20746 23a. Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shoot, or heart failure. Little nly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atheros C disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initial date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy certificate performed death? 1 ☐ Yes 1∐ Yes 2∏ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No Director: 2 Accident in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours To the Funeral Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DΟ

Registrar

State

30. Name and address of person who con

AUG 0

1

2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

pleted cause of death (Item 23a) (Type, Print)

🐲. Registrar's Signature

State

To the Funeral

29a. Certifier (Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mera

egistrar's Signature

Registrar DHMH 17 Rev 1/2001 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D16801

Baltmore, M) 21237

29d. Date signed (Month, Day, Year)

JUL 31 2008

	_	State Registrar	aryland		artment of tificate of			•	Reg. No.	008	2485	
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Max M.K. Zung						Month July 2	1, ^{Day}	008	2:40 P	
Examin	er	4a. Facility Name (If not institution, give street and number) 110 Garcia Lane				4b. City, Town, or Location of Death Rockville If Under 1 Year If Under 24 Hrs. 8, [M	4c. County of Death Montgomery 9. Birthplace (State or Foreign)		
Funeral Director	Completed by Funeral Director	5. Social Security Number 118-26-9797 Sex 1			Months Days Hours Min.			8. Date of Birt (Month, Da 10/02/	y, Year) 1922	Country China		
ne Maryland 8a-f show		10a. State 10b. County Maryland Montgomery		Town or Lo	2				10- 011		10d. Inside City Lim 1 ☐ Yes 2 🕱 I	
with the		10e. Street and Number 110 Garcia Lane			10f. Zip Code 20850				10g. Citizen of What Country? USA			
ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. of Health and Mental Hygiene. of the 27 is marked other than "netural", or items 23a or 28a-f show rother traumatic event. It a Medical Examiner must be notified at		11. Marital Status 12. Was Decedent 6	Married 1 XYes 2 No 1953−			3. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, € 1 ☐ Yes 2 🔀 No Specify:				or No- 14. Race - American Indian, Black, White, etc. Specify: Asian		
		(Specify only highest grade completed) (Give life. Elementary/Secondary (0-12) College (1-4or 5+)			edent's Usual Occupation be kind of work done during most of working DO NOT use retired) YSICIAN			ing	16b. Kind of Business/Industry Medical			
	To Be Col	17. Father's Name (First, Middle, Last) Bate Zung				Rose	Fon	<u>~</u>	Maiden S	Sumame)		
		19a. Informant's Name/Relationship (Type, Print) Alice Zung/Wife 20a. Method of Disposition	20b. Pla	110 C	Garcia]	Lane, R	ockv	ille, M	ary1	and 20		
Dallinole, Dermit, Pages 1 a Department of Hee importent: If Item any injury or othe		1 ☐ Burial 2 (*** Cremation 3 ☐ Removal from State ** 4 ☐ Donation 5 ☐ Other (Specify)	Fun	eral Chant	Choices	place)					, Virginia	
permit, Pages 1 Department of F Importent: If ite any injury or ot		21. Signure of Service Licensee 22. Name and Address of Facility Funeral Choices of Chantilly 14522L Lee Road, Chantilly, Virginia 20151										
Examiner Wedical Examiner Whysician and The prival-transit Th	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Atherosclerosis Due to (or as a consequence of): Non-Insulin Dependent Diabetes Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):										
ne death certific the attending p	Physician/Med	23b. Was decedent pregnant 1 Live birth	Vas decedent pregnant 1 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Month Day 1							•		
w requires that the bear signed by should be detact	by	Part it. Other significant continuous continuous to treat but not resulting in the underlying cause given in Fart i.							to the cause of death? Probably 4 □Unkno			
sician: The law re certificate has bee irector, page 2 sho	tion: To Be Completed					10'		perfo	utopsy prior to completion of cause death? es 2 ♣ No 1 ☐ Yes 2 ☐ No			
ding Physician: The law requires the law requires the law requires the law requires the law requires the law requires the law requires the law requires the law requires the law requires the law requirements of the law requ		25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injur (Month, Day)										
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)								Rural Route Number,		
he Hospi in 24 hou he Funer pletely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To ti Withi To ti comp	Σ	29b. Signature and title of certifier Mak Kir M				29c. License number D27865			29d. Date signed (Month, Day, Year) 07/22/2008			
	11								•	•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 28e, f per me, get 108/01/08dhb 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 25 July 2008 9:15 p Walter J. Zawadski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 XM 2 ☐ F 87 29, 1920 **Director** 062-18-3199 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Woolca Eventure must be really dial 1 ☐ Yes 2 ☑ No Director Baltimore Monkton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 16514 Garfield Ave. 21111 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 NyYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: à White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 73 th and Mental Hygiene. **7 is marked other than** "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Domino Sugar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alexander Zawacki Anna Izworski ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 a. Department of Heat. Important; If item 27 any Injury or other once. Joanne Duffy/ Daughter Monkton, 16514 Garfield Ave. Md. 21111 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 7-30-08 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) ^{22. Name and Address of Facility} Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signa Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** twom disease or condition resulting in death) OMPLICATION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the burial-transit Due to (or as a consequence of) physician Physician/Medical sate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Day 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ DEMENTIA 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐ Yes of Vital funeral director, 25. Was case referred to medical gxaminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurr burned self u 28a. Date of Injury 28b. Time of Injury To the Hospital or Attending Plantin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death After Certification: Division 1 Natural 5 Pending investigation 23 Wilkhowny 1 ☐ Yes 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury Athome arm street, factory, office huilding, etc. (Specify) 28f. Location (Street and Number or Bural Route Number City or Town, State) 16514 Carfield Ave. 4 Homicide 144 sanc **∂ ਰ €Monkton, MD** as 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Favilane MD 555 W. Towsontown

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Items 23a, 25 per me all 23a, 25 per me a 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year P M Sr. July /Medical Paul Dewain Brown 2008 8:39 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7 Feb 26, 1917 9. Birthplace 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ace (State or Foreign X□M 2□F **Funeral** 217-10-1454 Usual Residence of Fig. Director Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Cumberland X ☐Yes 2 ☐ No Director MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 by Funeral 1303 River Avenue Je. Was Decedent Ever in U.S. Armed Forces?

X□Yes 2□No
If Yes, Give
Year or Dates: WW II 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕇 No Specify: white Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of Cumberland Maintenance 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sallie Betty Alkire Brown William Alexander Brown မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode)
P.O. Box 8 Wiley Ford WV 26767 19a. Informant's Name/Relationship (Type. Print) Monna Johnson niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1
Department of H
Important: If ite
any injury or ot 1

Burial 2 □ Cremation 3 □ Removal from State 7/13/2008 MD Sunset Memorial Park Cumberland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Physician disease or condition resulting in death) /Medical AMON ASPROVED BY MEDICAL EXAMINER Du to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). or Attending Physician: he law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, CERTIF Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 20VN 1 [vinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; of completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

122

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

July // , 2008

National Hwy LaVale MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 9-2-08 vt Amend #25 & PII per ME e881 7/25/08 TT amend 1 tems 16a-18 per 1h g883 9-2-08 vt State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Thomas Jefferson Bagby 05 13 2008 10:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Comm. Hospital Cheverly Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Sex XX M 2□F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 223-20-4771 94 Director 02/20/1914 Virginia Usual Residence of Decedent 10a State 10b. Count 10c, City, Town or Location 10d. Inside City Limits show Examiner must be notified at Director 1XYes 2□No MD Prince Georges Upper Marlboro 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 "natural", or items 23a 4808 Woodford Lane Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 20772 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ⚠ Yes 2 ☐ No If Yes, Give 10/2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1942-45 1 ☐ Yes 2 No ģ Widowed 4 □ Divorced Specify: Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Boiler Engineer the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Dept. Of Army than, Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 18. Mother's Name (First, Middle, Maiden Surname) is marked other 17. Father's Name (First, Middle, Last) Unknown Be Sarah Dudley Henry Bagby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 4808 Woodford Lane, Upper Marlboro, MD 20772 Renee Tyler/Grandaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1X Burial 2 □ Cremation 3 □ Removal from State Dinwiddie Memorial Pk 05/23/2008 Dinwiddie, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tucker Funeral Home 21. Signature of Funeral Service Licensee a MD. 278 415 Halifax Street, Petersburg, Virginia 23803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Peripheral Vascular Disease Sequentially list conditions, if et y, boding to it, it ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Dun to for as a nonsequence of The law requires that the death certificate be executed Aortic Stenosis burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical Cardio Myopathy the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed Ulcer Wound Infection and Gangrene Left/foot-leg 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy End Stage Renal Disease on Hemobiasis Hemodialysis performed? Yes 2 No certificate 1☐ Yes Physician: Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1[XYes 2□ No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death After ! 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1XXNatural 5 Pending investigation Injury s after death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C filled XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO D0057636 05/14/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Dr., Cheverly, MD Patricia Eben 20785

Registrar

State

31. Date filed (Month, Day, Year)

JUN 03 2008

32. Registrar's Signature

08-05557 Johnathan Berry Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 24861 Certificate of Death 1- For State Reg. No. Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day July 20, 2008 1800 hrs Jonathan Michael Berry Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Raltimore University Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours Days Country) Michigan Director 09/16/1988 381-11-8518 19 Yrs 2 F 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Yes 2 X No s 23a or 28a-f show e notified at once, Harford Aberdeen Proving Ground MD the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e, Street and Number 21005 Alpha Company 16th Ordnance Ba USA 14. Race - American Indian, Black, with 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married death 2 Married 1 X Yes Specify: White -Baltimore, MD 21215-0036
permit - Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or
injury or other traumatic event, the Medical Examiner m Yes 2 No specify: Give Year Widowed Divorced þ 6b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+ U.S. Army Soldier 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tammy Sue Berry Virgil Keith Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6734 West 104th St. Fremont, MI 49412 Virgil Keith Thompson/Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Broughman, Michigan 07/30/2008 Woodville Cemetery Donation 5 Other Specify: 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Liga 6512 NW Crain HWY Bowie, Maryland 20715 Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Retween Onset and failure. List only one cause on each line Death /Medical Hanging Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last 1 per me g882 8-1-08 vt Physician/Medical AMENDED UNPENDED physician the burial -Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death attending 1 for use as th past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown hed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 ✔ No 3 Probably 4 Unknown 2 Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 1 🗸 Yes No 2 ✓ Yes 2 this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 / Inpatient 2 Residence 6 Other Nursing Home 5 ER/Outpatient 3 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 27. Manner of Death After Subject asphyxiated himself Certification FOUND: Natural Yes 2 V No Director: Pending within 24 hours after death.

To the Fineral Director: Jul 19, 2008 0230 hrs Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be determined (Specify) military barracks 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29 c. License number 29b. Signature and title of certifie July 21, 2008 O.C.M.E. rithoul, s of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 31. Date filed (Month, Day) Registrar's Signature State

ORIGINAL

OCME

Registra

			1 - State of Maryland / Department	artment of Health and Mertificate of Death	ental Hygie _{Reg.}	ne No. 2008	24862
	Physici		1. Decedent's Name (First, Middle, Last) Frances Brown		2. Date of Death	Day 72008	3. Time of Death 8:05 P M
	/Medio Examir		4a. Facility Name (If not institution, give street and number) Sacred Heart Home	4b. City, Town, or Location of Death Hyattsville		4c. County of Death Prince Geo	L
	Funeral Director	0	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1	•	8. Date of Birth (Month, Day, Ye 10/11/19	ar) 9. Birthp	lace (State or Foreign try) ath, WI
	e Maryland 3a-f show tifled at	ctor	Usual Residence of Decedent 10a. State			11	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the	I Dire	10e. Street and Number 5805 Queens Chapel Road	10f. Zip Code 20782		Citizen of What Coun	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Mudical Evan, the rough by notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ₩ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Vas Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto F □Yes 2X No Specify:		ited State 14. Race - Americ Black, White, e Specify: Wh	an Indian,
Baltimore, Maryland 21215-0036	d within 72 hor giene. ir than "naturi I'm Modical I	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Deceded (Give life. L.	lent's Usual Occupation kind of work done during most of workin IO NOT use retired) aker	g	. Kind of Business/Ind	dustry
/land	uld be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) Walter Luczynski	18. Mother's Name Anna Mary			
Mar	d 2 sho th and 7 is ma trauma	ır ə		g Address (Street and Number or Rural			
nore,	ages 1 an		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	natory`or other place)	ate 20c	. Location - City or To	wn, State
Baltil	permit. P Departme Importan any Injur once.	-	21. Signature of Funeral Service Licenses	n Crematory 7/15 Name and Address of Facility sch's Funeral Home	4739	exandria, Baltimor ttsville, I	e Avenue
F	hysician	0.7	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a	er the mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
É	/Medical Examiner	ie.	Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate rouse (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Failure to thri Due to (or as a consequence of):	ve			
O. BOX 6	attending for use as	Physician/Med		Ectopic pregnancy		23d. Date of delive Month	ary Day Year
ecords, P.	w requires that the or been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the un Poor intake, hiatl hernia	derlying cause given in Part I.		co use contribute to the	
al Reco	r: The law re icate has bee r, page 2 sho	Completed			24a. Was an autopsy performed 1 □Yes 2 🛣	? prior to cor death?	psy findings available mpletion of cause of 2 ☑ No
VITA	ysiciar is certil directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death t 3 □ DOA Other: 4 🖾 Nursing Hom		e 6 ∏Other (Specifi	v)
o noi	ath. ath. r: After th	ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day, Year) Injury		Bd. Describe how in		
	out the rospital or Autening Priystcart. The law within 24 hours after death. To the Euneral Director: After this certificate has completely filled in by the funeral director, page 2.8	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streeth building, etc. (Specify)	et, factory, office	8f. Location (Street City or Town, Si	t and Number or Rura tate)	l Route Number,
	in 24 hou in 24 hou he Funer pletely fil	edical	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death (2 ■ Medical Examiner: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, a restigation, in my opinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
/	with solution	Σ	29b. Signature and title of certifier Chow duy, mi	29c, License number D43121	29d.	Date signed (Month, 1	
	190		30. Name and address of person who completed cause of death (Item 23a) (Type, F Nuru Chowdhury, 15216 Dino Drive, Bur	Print)	66		
	Sta Registr		31. Date filed (Month, Day, Year) JUL 1 8 2008 32. Registrar's Signature				

Physician /Medical Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene, interportant, or Nems 23a or 28a-f show Important: If Item 27 Is marked other than "natural", or Nems 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at any once.

attending physician and for use as the burial-transi certificate has been signed by the rector, page 2 should be detached

Division or Vital Records, P.O. Box 68760,

	23a. Pat1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line.		Approximate Interval Between Onset and Death						
	Immediate Cause (Final disease or condition resulting in death)	a. Acquired Ammune deficiency Synd	rome	Onset and Deadi						
cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b								
ysician/inedical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months2 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delive Month	<i>ie</i> ry Day Year						
Completed by Physi	Part II. Other significant conditions o		24b. Were aut prior to c death?	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of						
i)	25. Was case referred to medical	26. Place of Death (Check only one)								
0	examiner? 1 ☐ Yes 2☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence	6 □Other (Spec	lfy)						
cation: I	27. Manner of Peath Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No								
Cermic	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, Sta	and Number or Ru te)	ral Route Number,						
Medical										
IME	29b. Signature and stitle of certifier	29c. License number 29d. I Scompleted cause of death (Item 23a) (Type, Print)	oate signed (Month	, Day, Year) 2008						

State

Registrar

DIVYA 31. Date filed (Month, Day, Year)

JUL 1 8 2008

1925 Greenway Center Drive, Greenself, MD 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are begible State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OUISE てもも 100 M 4a. Facility Name (If not institution, give street and number, 4h City Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Harwood Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Month, Day, Year 07/14/1908 9. Birthplace (State or Foreign Min. Months Days Hours 579-20-5634 100 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No N/A N/A Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1848 Capital Avenue, N.E. 20002 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 Yes 2 No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Herman Jenkins Susie Butler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 South Cherry Grove Ave., Apt. 103, Annapolis, MD Claudia Harris/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cemetery 07/21/2008 | Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 Approximate Interval Between Onset and Death Part 1 _enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. xk, or heart failure. List only one cause on each lin increase (Final disease or condition resulting in death) EMEN Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 🗔 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospice Other: 4 Nursing Home 5 Residence 6 Other (Specify) House 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) d manner stated.

/Medical Examiner P.O. Box 68760, Division of Vital Records,

Physician

Examiner

Funeral

Director

of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expression or is used the modified at

Department of H Important: If iter any Injury or ott once.

Physician

death \

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

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Physician/Medical

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a Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death.
2 Funeral Director: After this certificate has been signed by the attending physician and elely filled in by the funeral director, page 2 should be detached for use as the bunal-transit

Certification: To completely within 2 To the I

Medical

Registrar

Name and address of per on who completed ICHAEL

29b. Signature and title of ce tifier

cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) JUL 17 2008

32 Registrar's Signature

DEFENSE HIGHWAY

State of Maryland / Department of Health and Mental Hygiene

2008 24865

Physic ledical Exam		1- For State Registrar		Cer	tificate of	Death			Reg. No.		
		Decedent's Name (First, Midd						2. Date of D Month July 16,	eath Day	Year	3. Time of Death 0744 hrs
4 h		4a. Facility Name (if not institution 29029 Superior Circle	on, give street and n	umber)		tb. City, Town, or I	ocation of		4c.	County of Dea	th
Funeral		Social Security Number	6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under	24Hrs. 8. Date of	Birth (MM/D	D/YYYY) 9. B	irthplace (State or
Director		214-90-9972	1 X M 2 F	30	Yrs.	Months Days	Hours	Min. 9/:	27/19	77 Fore	^{ign} ^{country)} Washington,
w any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locati	on					10d. Inside City Limits
Aaryland 28a-f show 1 at once.	햕	MD Talbe	ot	Eas	ton	10f. Zip Code			10a Citiz	en of What Co	1 X Yes 2 No
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: (I filem 27 is marked other than "natural", or items 23a or 28a-f sho are other traumatic event, the Medical Examiner must be notified at once.	Director	29029 Superio	r Circle			21601				ted Sta	ŕ
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after de al'', or i	by Fu	3 Widowed 4 Div	1 Yes vorced If Yes, Give Ye		1 X	Yes 2 No	specify:		S	Specify: H	ispanic
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	្ង	17. Father's Name (First, Middle	e, Last)					Name (First, Middl			
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and 2 should lealth and Me tem 27 is ma traumatic ev		Christina D.		wife	4.			erorRuralRouteN cle, East			
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MOF Pages tent of mrt: If rr othe		1 Burial 2 X Crematio 4 Donation 5 Other S		olato	rematory or oth	n Cremato:	$_{\mathbf{v}}$	7/23/08	_ A1	exandri	ia. VA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If liter a 75 is marked other than injury or other traumatic event, the Medical injury or other traumatic event, the Medical		21. Signature of Funeral Service	e Licensee	0 1 7	22. N	ame and Address	of Facility	4	4739 I	Baltimo	re Avenue
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8760, tificate be ng physicias the buri	¥	IF FEMALE: 23b. Was decedent pregnant in t	he 23c. If yes,	outcome of pregr		al death 3	Ectopic p	roanone.		Date of delive	'
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Box the death c y the atten hed for us	Physicia	1 Yes 2 No 9 Un Part II. Other significant condit	9 Unkn					220 Di	d to b a sec		o the cause of death?
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of Vital Records, P.C. ng Physician: The law requires that Wer this certificate has been signed I meral director, page 2 should be deta	Completed						-	24a. W			autopsy findings available
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Division Hospital or Attend 24 hours after death. Funeral Director:	Certification:		Id not be (Specify)			•	<i>3</i> ,		n, State)		,
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e Host 124 ho e Fune letely fi		one) 2 ✓ Medical Exa	miner:On the basis and manners	of examination ar stated.	nd/or investigati	on, in my opinion,		rred at the time, da			
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To the within: To the comple	Med	29b. Signature and title of certific A le Cun Sia 30. Name and address of person	sself N	se of death (Item	23a)	O.C.N				17, 2008	ontri, Day, Yearj
To the Hosp within 24 hosp completely if	Med	Nolan Bia	sel N	se of death (Item	•		1.E.	MD 21201			оппп, µау, чеаг)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year **Physician** 4:35 P.M. JOSEPH SAMUEL FISHER /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner timore Was nington 1 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1**X** M 2□ F 213-30-2978 75 OCTOBER 20, 1932 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evuninatinust continued at once. Director 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE Figher Joseph Baltimore, Maryland 21215-0036 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7007 CRESTHAVEN DRIVE 21061 UNITED STATES by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1∑Yes 2 No 1951− If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2**X** No Specify: Specify: WHITE 1955 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ELECTRONIC TECHNICIAN DEFENSE CONTRACTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DAVID FISHER ESTHER KATHRYAN MERRICK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID J. FISHER/SON 236 THREE CREEKS DRIVE, CENTREVILLE, MD 21617 20b. Place of Disposition (Name of CHESAPEARE O'CREMATTON 20a. Method of Disposition 20c. Location - City or Town, State JULY 16 2008 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State STEVENSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) CENTER 22. Name and Address of Facility FELLOWS, HELFENBEIN AND CREMATION AND FUNERAL CARE, P.A., 814 B. ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Licensee M00672 that caused the death. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) P.0. the 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s 24a, Was an autopsy his certificate h I director, page 2 **X** No 1 ☐ Yes 2 ☐ No 1 ☐Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Discritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

20 +1/3

State Registrar 30

. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIRIA

GA

31. Date filed (Month, Day,

2002

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene giene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Leon Carlisle Foreman July 2008 14 20:22 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Hospital Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/23/1939 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 68 578-54-3371 DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Prince George's Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6203 Kilmer Street 20785 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 1960 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: Black 3 ☐ Widowed 4 🕅 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Shoe Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leon Carrell Blanche Foreman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Campbell/Daughter 6203 Kilmer St., Cheverly, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🎇 Burial 2 🗆 Cremation 3 🗆 Removal from State 1 Veterans 7/22/2008 Cheltenham, MD 22. Name and Address of Facility Strickland Funeral Services 4 Donation 5 ☐ Other (Specify) Maryland 21. Signature of Funeral Ser 5500 Allentown Rd.,Camp Springs,MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Respiratory Failure disease or condition resulting in death) Due to (or as a consequence of): Sepsis Due to (or as a consequence of): Pneumonia Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown

Physician /Medical Examiner

physician and s the burial-tran-

Hospital or Attending Physician: The law requires that the death certificate be executed

ours after death.

eral Director: After this certific filled in by the funeral director.

within 24 hours a
To the Funeral I
completely filled

6

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

29a. Certifier

(Check only one)

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Madical Expraise trausal benefited at once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

autopsy performed 2 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 □Yes

1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

Hospital:

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

24a. Was an

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature ap

29c. License number

29d. Date signed (Month. Day. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Cetta, 9901 Medical Center Drive, Rockville, MD 20850

State Registrar Date filed (Month, Day, Y

25. Was case referred to medical examiner?

32. Registrar's Signature

			For State Registrar	State of Marylan		artment of F rtificate of I		Mental Hy	giene Reg. No.	2008	24868
	Physici		Decedent's Name (First, Middle, Let JEREMIAH	GREEN				2. Date of De Month JULY 5	eath Day	Year	3. Time of Death 6:15 A M
£	/Medic Examin Funeral Director		4a. Facility Name (If not institution, given HEARTLAND NURSING 5. Social Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Second Security Number 6. Second	G HOME Sex 7. Age (In yrs.	last birthday) 78 Yrs.	4b. City, Town, or HYATTSV If Under 1 Year Months Days	LLE If Under 24 Hrs. Hours Min.		PR:	County of Death INCE GEO	ORGE 'S pplace (State or Foreign
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County DC 10e. Street and Number 101 P ST., S.W. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest gridents) Elementary/Secondary (0-12) 9th 17. Father's Name (First, Middle, Last MACK E. GREEN 19a. Informant's Name/Relationship (JOHN GREEN/BROTH 20a. Method of Disposition 1 Burial 2 Cremation 3 CA County (Specify only in the state of the state o	#2 12. Was Decedent Ever in U. Avmed Forces? 11 Yes 2 No If Yes, Give Year or Dates: 12/14 ducation adde completed) College (1-4or 5+) Type. Print) IER Removal from State fy) WAS 12. Was Decedent Ever in U. Avmed Forces? 11. Yes 2 No II. Yes 2 No II. Yes Give Year or Dates: 12/14 20b. Forces Chile	1/51 16a. Decec (Give life. I) 19b. Mailin 3298 Place of Disponemetery, cremetery, cremetery.	10f. Zip Code 20024 Was Decedent of H If Yes, specify Cuba 1 Yes 2 No Jent's Usual Occup kind of work done to DO NOT use retired TRANS	specify: ation during most of word) SFORMER 1 18. Mother's Nam DAISY LA and Number or Ru DLN DR., DRY 7/1 ss of Facility CA	pecify Yes or No o Rican, etc.) king INSTALL AWSON ral Route Numb N.E. #9 Date L7/08 APITOL M	10g. Citiz UN: 16b. Kin PR: , Maiden S er, City or 008 W. 20c. Loc BELT:	zen of What Cou ITED STA 14. Race - Ameri Black, White Specify: BLA(and of Business/Ir IVATE Surname) Town, State, Zi ASH., D cation - City or T TSVILLE	ATES ican Indian, t, etc. CK ip Code) C. 20018 Fown, State , MD.
00/00,	hysician and hysician and bhysician and bhysician and bhysician and street the purial-transit	edical Examiner	23a. Part1. Enter the disease or comshock, or heart failure. Historial disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	uence of): PD1A1 uence of):	er the mode of dyin OMARY LINFAS MURCO	AFRE	ST		mc_	Approximate Interval Between Onset and Death
	atth certi attending for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	ıl death 3□	Ectopic pregnancy Other (specify)			23	3d. Date of deliv Month	very Day Year
COLUS, T	w requires that the d been signed by the should be detached	ρ	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the un	nderlying cause give	en in Part I.	11			the cause of death?
ומו חבכם	rsician: The law re s certificate has bee lirector, page 2 sho	e Completed	25. Was case referred to medical					1□ Yes	osy ormed? 2 🔀 No		opsy findings available ompletion of cause of
	ng Phy fter this ineral d	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work M 1 🗆 Y	4 DXINUTSING H	ome 5 ☐ Resid	dence 6 now injury		al Route Number.
5	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A pompletely filled in by the fu		29a. Certifier 176 Certifying Ph	building, etc. (Specify nysician: To the best of my knowniner: On the basis of examinate	wledge, death	occurred at the tim	ne, date and place	City or Tov	vn, State)	and manner as s	stated
1		Medical	29b. Signature and fitte of certifier	and manner stated.		29c. License				e signed (Month,	
)	30		30. Name and address of person who	completed cause of death (Item		Print) PAOLC	as FI	-0.66 -5	CAT	MADUL	008 1003 20770
	Star Registra	_	31. Date filed (Month, Day, Year) JUL 1 8 2008	32. Registrar's Signar	ture.	a-1100	WHY Q	NO CONTRACTOR OF THE PARTY OF T	ピロ	1411)10	- JAMIL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death .^{Day}2008 **Physician** July 15, 11:15 A M Frances G. Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Ginger Cove Health Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Sept.4,1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M China 215-18-9270 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinet must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2/No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 3305 River Crescent Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ∐Yes ZXXNo If Yes, Give Year or Dates; 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 🏋 No Specify White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Realtor RealEstate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James E. Griffith Fanny B. Schramm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James B. Millette, Jr. / Son 1734 Lancaster St. Baltimore, Maryland 21231 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2/C) Cremation 3 ☐ Removal from State 7/17/2008 4 Donation 5 ☐Other (Specify) Baltimore Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tra resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the d 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performed? 1 □ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) QRE July 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Njide Udochi, M.D., 9055 Chevrolet Drive, Ellicott City, MD 21042 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1, perPHYS., G882, 8/15/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mary **Physician** Johnson Teresa 2008 Sulv /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Easton Hospita 5. Social Security Number 6. Sex 7. Age If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Year) Days 1 □ M 2 🖫 F Months Hours Min. Director 214-36-4306 67 8/31/1940 Washington, DC Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, If a Marical Examinar must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Talbot Tilghman 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21603 Chicken Point Road 21671 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Director Parks & Recreation City of Hyattsville 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George T. O'Hare Mary Theresa McQuillan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert T. Johnson / husband 21603 Chicken Point Road, Tilghman, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Olivet Cemetery 4 Donation 5 DOther (Specify) 7/21/2008 Washington, D.C. 21. Signature of Funeral Service Licens 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Anoxic **Physician** brain /Medical Due to (or as a consequence of): Examiner ardiac arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician and for use as the burial-trar P.O. Box 68760, Physician/Medical olitis IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ♠No Month 4 ☐ Pregnant at time of death Day Year 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 ☐ Yes 2 No Completed 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy perform certificate 2 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? completely filled in by the funeral director. Be 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cin D54488 7-17-2008 0

Registrar
DHMH 17 Rev 1/2001

State

Johnson, Mary

Washington

Easton NID ZIGOI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

219 5

32. Registrar's Signature

Sa

Year)

Bennett

JUL 1 8 2008

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

08-05346	
Frankie Moore	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certificate of	of Death		Re	eg. No.	108 2487
Physicia Medical Examir	ier	1. Decedent's Name (First, Middle,La Frankie H, Moo	re				2. Date of Deal Month July 12, 20	Day Year 008	3. Time of Death 1105 hrs
·. 2	2	4a. Facility Name (if not institution, gi 6429 Livingston Road Ap	t. 201		4b. City, Town, Oxon Hill	or Location of Deal	th	4c. County of D	
Funeral Director		5. Social Security Number 265-94-1549 Usual Residence of Decedent	ex 7. Age (In	yrs. last birthday)	Months Da		n.		D. Birthplace (State or oreign Country) Florida
any		10a. State 10b. County	100	. City, Town or Loc	ation				10d. Inside City Limits
daryland 28a-f show I at once.	٥	Maryland Prince	George's	Oxon Hi	1				1 Yes 2 No
after death with the Maryland al", or items 23a or 28a-f sho iner must be notified at once	ÖİĞ	10e. Street and Number 6429 Livingston	Road Apt. 2	01	10f. Zip Code 2074.		1	Og. Citizen of What United	•
death with	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 X	If	as Decedent of F Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert	Specify Yes or No o Rican, etc.)	- 14. Race - A White, e	American Indian, Black, etc.
after cral", o	by F	Λ.	If Yes, Give Year	1_	Yes 2 X				Black
72 hours n "natur	ted	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	nly highest grade complet College (1-4 or 5+)	ed) 16a. Decede during	ent's Usual Occup most of working li	pation (Give kind of fe. DO NOT use re	work done tired)	16b. Kind of Busin	ess/Industry
0036 within 7: ene. er than	Completed	12			Driver			Federal	Government
nore, MD 21215-0036 ages I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. tt: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.	ရှိ မြ	17. Father's Name (First, Middle, Last Frank Moore)				ne (First, Middle, Middle, Mil)	,	
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MD and 2 sho salth and em 27 is raumati		Maurice E. Moore		20b. Place of Dispo			pad, Hill	liard, FL	
Baltimore, MD 2121! permit. Pages I and 2 should be fil Department of Health and Mental H Important: If item 27 is marked injury or other traumatic event, t	ı	1 Burial 2 X Cremation 3	Removal from State	crematory or o	other place)	· · ·			
Baltin permit. Pa Departmet Importan injury or		4 Donation 5 Other Specify 21. Signature of Funeral Service Use			remator	ss of Facility Co	18/2008	Edgewat	er, MD neral Home
Per De lini		allen /	Awann	J 1 6	160 Oxoi	n Hill Ro	oad. Oxor	n Hill. M	D 20745
Physician /Medical		23a. Part I. Enter the disease, or comparing failure. List only one cause on e	ach line.		the mode of dyin	g, such as cardiac	or respiratory arre	est, shock, or heart	Between Onset and
xaminer		Immediate Cause (Final disease a or condition resulting in death)	Contact Gunshot V						Death
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ecuted and - transit	۳ ي	events resulting in death) Last	Due to (or as a conseque	nce of):					
760, icate be exe physician a	/Medical	UNPENDED	AMENDED			_			
8760, tificate be ng physic as the bun	2	IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome of		etal death 3	Ectopic pregr	nancv	23d. Date of de Month	livery Day Year
P.O. Box 68 that the death certifing hed by the attending detached for use as	Physiciar	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time	of dooth	Other (Specify)				
t the de		Part II. Other significant conditions	9 Unknown	not resulting in the	underlying cause	given in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
r, P.O.	٦				· <u>-</u>		1 Yes	2 No 3	Probably 4 Unknown
ords w requ as been should	Completed						24a. Was autop		re autopsy findings available r to completion of cause of
Rec The la icate ha	E O						perfor 1 ✓ Yes		th? Yes 2 No
Vital Rec ysician: The his certificate director, page	a B	25. Was case referred to medical examiner?	Hospital:			Other Nurs			
n of V ding Phys 1. After thi funeral di	음 :	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Injury	2 ER/Outpatier 28b. Time of		jury at Work?		Residence 6 🗸 (Other: Scene
ion trendin leath. tor: A the fun	atio	1 Natural 5 Pending 2 Accident Investigati	FOUND: Jul 12, 2008	FOUND: 1106 hrs	1	Yes 2 V No	Subject sho	t self	
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tell filled in by the funeral director, page 2 should be detached for use as the burial - transit	[€	3 Suicide 6 Could not determine	be 28e. Place of Injury -	At home, farm, stre	eet, factory, office	building, etc.	28f. Location (5 or Town, S 6429 Livingsto	Street and Number of tate) on Road Apt. 201	Or Rural Route Number, City
Division To the Hospital or Attenwithin 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physic	an To the best of my known the basis of examinat	wledge, death occu			d due to the caus	e(s) and manner as	stated.
To the within to the complete	ᄝᆫ	29b. Signature and title of certifier	and mariner stated.			nse number	and amo, date		(Month, Day, Year)
(3)			/ (.M.E.		July 13, 2008	
OCME	3	30. Name and address of person who	•		4.D:		4D 0 100 :		
#35755 S	to 13		puty Chief Medical I		1 Penn Stree	et, Baltimore, N	MD 21201		
Sta Registr	ar `	31. Date filed (M88th 2008 ar)	and A	Soule !					

			For State Registrar	State of N	Maryland		irtment of tificate of		and M	-	giene Reg. No	200	3 6	24874
	ysicia Vedica	_		Simmons						2. Date of De Month July 1	1, ^{Da}	800	Year	3. Time of Death
)	amine		4a. Facility Name (If not institution, give str 124 Cindy Lane 5. Social Security Number 6. Sex		er) Age (In yrs. las	st birthdav)	4b. City, Town, Capito If Under 1 Yea	Heigh	nts	8. Date of Bir			e Ge	eorge's
Fun Dire	ctor		242-34-4617 1□1 Usual Residence of Decedent	M 2 ⊠ F	81	Yrs.	Months Day		Min.	8. Date of Bir (Month, Da Aug. 3	iy, Year) I, I		Nort	ace (State or Foreign try) Ch Carolina
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them ZT is marked other than "natural", or Items 23a or 28a-f show	y Injury or other traumatic event, the <u>Medical Examiner must be notifled at</u> nce.	To Be Completed by Funeral Dire	1 Never Married 2 Married 3 Nidowed 4 Divorced 15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	2. Was Deceder Armed Force: 1 Tyes 2 till fyes, Give Year or Dates tion completed) College (1-40 years 2. Print) Son	Cap Int Ever in U.S. S? No S: or 5+)	13. V 16a. Deced (Give life. L Com 19b. Mailin 124 (ce of Disponetery, cren 1 s Cre	Heights 10f. Zip Code 207 Vas Decedent of Yes, specify Cu Yes 28 Note that the control of Work don NOT use retire that the control of the	Hispanic Original Hispanic Origin Hispanic Original Hispanic Original Hispanic Origi	t of working tr's Name eliss er or Rural pitol 7/19 y Ste	(First, Middle, a Thom Heigh: Ale D/08 wart F	Uni 16b. K Go , Maiden as eer, City of ts, 20c. Lo	Specify: vernm Surname) or Town, Si MD 20 cocation - C C1 a1 Hc	America White, e Blainess/Indi	es an Indian, etc. Lack dustry Code) wn, State on, MD Inc.
Physical physician and Physici	ical ner transit	dical Ex	23a. Part Enter the disease, of complice shock or beart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Non- Due to (or a Ciga		Cell lence of): Smokin	Lung Car		cardiac oi	respiratory a	rrest,			Approximate Interval Between Onset and Death
The law requires that the death certificate be executed ate has been signed by the attending physician and	be detached	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions control	4□Pregnant 9□Unknown	2 ☐ Fetal d at time of dea	leath 3□ ath 5□	Ectopic pregnan Other (specify) derlying cause g			23e. Did t	Yes 2	□ No 3	h oute to the □ Proba	Day Year e cause of death? ably 4 Unknown by findings available
ng Physician:	ineral director	Certification: 10 Be Completed	25. Was case referred to medical examiner? 1	28e. Place of i	njury 2 Day Year)	28b. Time of Injury	28c. Inj	ther: 4 □ Nu ury at ork? □ Yes 2 □ N	rsing Hom	1 Yes (Check only cone 5 X Resided	ormed? 2 No one) dence how injui	pride de 1	or to comath? Yes (Specify	npletion of cause of 2□ No
To the Hospital or Attendi	gompletely fille	Medical		er: On the basis and manner	s of examination stated.	on and/or inv	29c. Licer	r opinion, dea	63	d at the time,	date an) and mann d place, an te signed (d due to	the cause(s)
Re	Stat gistra	~	31. Day yied (Month, Day, Year) JUL 1 7 2008		strar's Signatur		e name	nargu,	י עום	20//4				

amend #2 Per Phy State of Maryland / Department of Health and Mental Hygiene For Amend Items 25,27,28a-f per mers 2882 08/01/08dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Woolfolk May 29, Dorothea S. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collington House Prince George's Mitchellville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 578-24-2195 1 ☐ M 2 🛛 F Yrs. Director 92 Dec 19, 1915 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Mitchellville 1 X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 10450 Lottsford Road #345 Funeral 20721 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Government Elementary/Secondary (0-12) College (1-4or 5+) (Department of Navy) Clerk Typist <u>4 years</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roger Shumate ೭ Louise Butler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Hager Francis/Goddaughter 12603 Spriggs Request Ct. Mitchellville, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lee's Crematory 4 □ Donation 5 □ Qther (Specify) June 10, 2008 Clinton, MD 21. Simature of Funeral Service Linensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Parf 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arde Haldaund **Physician** Urosepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Understand Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a d be detached f Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Liver Mass, Pelvic Fracture, Aortic Regurgitation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform nis certificate has I director, page 2 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Senior Asst. Hospital: 1X Yes 2X ² 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1. Tr Notural 05/15/2008 Unknown M 2 Accident ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 XNo Subject fell out of bed. 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 10/150 Tottes form determined 4 Homicide #345 Mitchellville, MD Home within 24 hours a

To the Funeral I

completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D47603 June 6, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William F. DuBoyce, M.D. 12158 Central Ave. Mitchellville, MD 20721 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Physician /Medical Examiner **Funeral** Director

Director

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4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

28a-f show notified ral", or items 23a or Examiner must be r within 72 hours after "natural", or other traumatic event, the Medical permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other trailmests.

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division or Vital Records,

Physician /Medical **Examiner**

death certificate be executed burial-transit the attending physician the as signed by the a certificate After this

1. Decedent's Name (First, Middle, Last) Eugene Theodore Wugofski 07 2008 15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Childs Koad 928 Anne Annapol.5 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day) 6. Sex 1 ⚠ M 2 ☐ F 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 175-30-5454 72 09/23/1935 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Marvland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 928 Childs Point Road 21401 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1957–82 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 2 Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) C.E.O. Consulting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theodore Eugene Wugofski Jean Marcewicz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline E. Wugofski/Wife 928 Childs Point Road, Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 07/17/2008 | Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licenses 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Afheroscleros years Due to (or as a consequence of) odem Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last r as a con quence of) Due to (or as a consequence of): IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

31. Date filed (Month, Day, Year) State Registrar

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed gruse of death (Item 23a) (Type, Print) Chance Row Svite 180 Mark D. Phillips 137 Mitchells MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as success.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar's Signature

JUL 1 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24877 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 0:57 AM Month James H. Avampato 2008 23 July 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 06-13-1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Months 207-09-9829 86 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 27 No Bel Air MD Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21014 501 Giles Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 No 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) School Orchestra Director 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angelina DiGange Joseph Avampato 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Giles Street Bel Air, MD 21014 Margaret Avampato (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-26-2008 | Baltimore, MD Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signatur of Funeral Service Licenses Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reumon 6 day Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No anoxia Chronic Renal 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Propatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician /Medical Examiner Examiner

permit. Page Department c Important: If any injury or once,

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Medical Certification: To

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29b. Signature and title of certifier

al or Attending P s after death. al Director; After i within 24 hours a Hospital

> State Registrar

DHMH 17 Rev 1/2001

1 🕊 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

500 claser Chesapeated

Maryland

Amend 23 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death **Physician** CHARLES, AYERS 18:53 JUIY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTMORE BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9 - 4 - 1935 Birthplace (State or Foreign Country)
 VA **Funeral** 1**X** M 2□ F Days Hours 230-38-3009 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 No Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **HSA** 21222 Completed by Funeral 2051 Kelmore Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Steel 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Susie Miller Wilmer Ayers 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Personal Cheryl Culver -Rep. 2051 Kelmore Road, Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory | 8-1-08 Baltimore, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service License IPA, 2134 Willow Spring Rd, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 aa75 Immediate Cause (Final ASPIRATION PHEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ALZHEIMER'S ATMS 136 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE, DIABETES MELLITUS 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ASBESTOSIS Frontotemporal dementia 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier J. magiel, MD 29d. Date signed (Month, Day, Year)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, should be page 2 director, this or Attending after death. filled in by a Funaral comptetely within 2 To tha I

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Itam 27 is marked othar than "natural", or Itams 23a or 28e-f ahow

Baltimore, Maryland 21215-0036

?7 is marked other than "natural", or Itams 23a or 28e-f ahov traumatic avant, the Medical Examiner must be notified at

other

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permit. Page Department of Important: If

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Registrar

31. Date filed (Month, Day, Year) 04



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

D660 63

July 31,2008

the Hospital or Attending Physician; Division of Vital

within 24 hours after death.

To the Funeral Director: A completely filled in by the fun

30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD 31. Date filed (Month, Day, Year State

29b. Signature and title of certifie

Accident

Suicide

Homicide 29a. Certifier 1

3

Medical

Assistant Medical Examiner 32 Registrar's Signature

111 Penn Street, Baltimore, MD 21201 weren

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

28e. Place of Injury - At home, farm, street, factory, office building, etc.

28f. Location (Street and Number or Rural Route Number, City

July 30, 2008

29d. Date signed (Month, Day, Year)

or Town, State)

Registrar

AUL

determined

2008

(Specify)

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 25 per dr., g882,08694603dhb Death

Reg. No. 2. Date of Death **Physician** /Medical 4c. County of Death Examiner **Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at Yes 2□No Be Completed by Funeral Director Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes , → No Specify 3 Widowed 4 □ Divorced Baltimore, Maryland 21215-00 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Decedent's Disual Occupation (Give kind of work done during most of working life. DONOT use regrect) College (1-4or 5+) econdary (0-12) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event ပ 3 ☐Removal from State 5 Other (Specify) 21. Signature of Funeral Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician ehydration /Medical Due to (or as a nsequence of): Examiner Alcoholism Sequentially list conditions, if any loading to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner malnutrition The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD Probably 2 No 4 Unknown funeral director, page 2 should Be Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performi Yes 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 XYes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 Tyes filled in by the the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier (Check only one) within 24 I and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D0062735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch RavenBlvel Baltmore. odrna Jonna

State Registrar 31. Date filed (Month, Day, Year)

AUG 04

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2008-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death unty of Death TOWSON HORITIMONE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Sex. 1 M 2□ F Date of Birth (Mpnth, Day, Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Director Usual Residence of Decedent 10a. State 10b. Count City, Town or Location 10d. Inside City Limits than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 23 a or 28a-f shou limportant: If item 27 is marked other than "natural", or items 23a or 28a-f shou any Injury or other traumatic event, he Medical Examinat must be notified as 1 Yes 2 □ No Funeral Director Towa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12, Was Decedent Ever in U.S. Armed Forces? 1 (XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: BACI Ş A 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Collage (1-4or 5+) Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Şurname) ဂ 19a, Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) olumbia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Funeral Services 151 taltimore National Ma 21229 Halto. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nous mall Physician disease or condition resulting in death) 12aB /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown É Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autop periorme certificate 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 2 X No Other: 4 Nursing Home 5 Residence Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 6 Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 No 3 ☐ Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -MD endall taulkner 1 dusantown 2. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 4 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20a per fh g882 8-19-08 vt
State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** corge JU arras 200 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Deat Examiner towar toward umbia If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1XM 2□ F Yrs. Charlotte, N.C. 43 3-7-1965 Director 237-35-1362 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No N.C. Mecklenburg Director Charlotte 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 6151 Bevington Place 28277 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White Baltimore, Maryland 21215-0036 Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George G. Carras, Sr. Constance Castanes ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dean Carras 10933 Thornhill Club Dr. Charlotte, N.C. 28277 Bro. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-30-2008 | Charlotte, N.C. Evergreen Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home un a 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OUrs tkono /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the 9 I Inknown 9 Unknown cate has been signed by page 2 should be detach Part II. **Other significant conditions** contributing to death but not resulting in the u 🚣 rlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No iver tau 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 Inpatient 3□ DOA 2 ER/Outpatient Certification: To After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1 July 29, 2008 Colombia, MD 21044 30. Name and address of person who completed cause of death (Item Salvaterra 2. Registrar's Signature 31. Date filed (Month, Day, Year) 2008 Registrar AUG 0 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 8:25 a. M Betty L. Carter 2008 /Medical August 1 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore 8. Date of Birth (Month Day Year) 9. Birthplace (State or Foreign Country) T7A 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 T F 66 VA Director 219-38-7446 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD 11√2 Yes 2 □ No n/a Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1709 E. 35th Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married African-American 1 ☐ Yes 2 No δ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "reamy injury or other traumatic event, the "lead once. Elementary/Secondary (0-12) College (1-4or 5+) Supervision Maryland State Government 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Ball Louise Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Memita Smith/Sister 3610 Woodlea Avenue, Baltimore,MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest Veterans 20a. Method of Disposition 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 21. Signature of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ECTAL **Physician** MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dee to (or as a consequence of) be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) 1 ☐ Yes 2 No Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has b rector, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy 1 ☐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \square Nursing Home 5 \square Residence 6 \nearrow Other (Specify) 1 ☐ Yes 2 No Certification: To Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D64395 AUGUST 1. 2008

State Registrar DANIEUE DOBELMAN, MO 6565 N CHARLES ST. SUITE 209 BALTIMORE, MO 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 7: 18PM 08 2009 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F 216-34-6869 Director 70 6-30-1938 WVUsual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 Nes 2 No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 3479 Dunhaven Road 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. within 72 hours after 1 ∐Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If them 27 is marked other than any Injury or other traumatic event. The Homemaker
18. Mother's Name (First, Middle, Maiden Surname) 11 Own Home 17. Father's Name (First, Middle, Last) Be Robert W. Carter ဂ္ Eda Mae Venable 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Ken White - Son</u> 3479 Dunhaven Rd, Dundalk, MD 21222 of Disposition (Name of Date 200. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 → Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Lawn Cemetery 8-5-08 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee to that 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Myocardia arction disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any leading I impurity cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) P.O. 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perforn certificate 2 No 1 ☐ Yes 2 ☐ No 1 □Yes or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No this , 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c 28d. Describe how injury occurred After 5 Pending investigation i 24 hours after death.

e Funeral Director: A letely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

EASTERN AVENUE BALTIMORE, MARYLAND 21224

AGBOR-ENOH M.D. PhD 4940

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 12:00P M Aug. Elizabeth Williams Dixon /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2230 Sams Creek Road Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 4, 1944 Birthplace (State or Foreign Country)

PA 5. Social Security Number 7. Age (In vrs. last birthday) 6 Sex **Funeral** Months Days 1 □ M 2 □ X 63 Dec. 199-32-7527 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or Items 23a or 28a-f show the Wolcal Examination outbods 1 □Yes XX No Director MD Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 2230 Sams Creek Road 21157 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 }q If Yes, Give Year or Dates: 1 ∐Yes 2M∑No Specify: Specify: White ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 sho lid be filed within 7. Department of Health and Lental Hygiere. Important: If Ifom 27 is marked other than "na any Injury or other traumatic event, the Macanone. Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John L. Fehlinger Anna Mae Owens ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Marie Williams 2230 Sams Creek Road Westminster, MD 21157 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State South Carroll Crematory Aug. 7, 2008 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalure of Funeral Service Licenses 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 23a Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I remediate Cause (Final disease or condition resulting in death) **Physician** Coronary -Hyear, Diseuse /Medical Due to (or as a conse pence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the daying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Mollita 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hrome طانءورطه 24a. Was an page 2 After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nasir 735711 Mokhtar 800L 10 180 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Westminster, MD, 21157 Naviv Washington 31. Date filed (Month, Day, Year) 2008 Suite 100 32, Registrar's Signature State AUG 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1 1 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 2008 Year Russell E. Denney 9:12 PM /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Dove House Westminster Carroll 5. Social Security Number Sex XXM 2□ F 7. Age (In yrs, last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/19/1924 Birthplace (State or Foreign Country) **Funeral** Days 298-16-7910 Director 84 Ohio Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at Director MD 1 ☐Yes 2√☐ No Carroll Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1830 D Vincenza Dr. Funeral 21784 United States 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 No WW 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. xxYes 2 ☐ If Yes, Give Year or Dates 1 ☐ Never Married XX Married WWII Baltimore, Maryland 21215-0036 Specify: White δ. 1 ☐ Yes % No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Accountant Knox Glass 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David F. Denney ပ Lula Belle Cochran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1830 D. Vincenza Dr. Eldersburg, MD 21784

Date 20c. Location - City or Town, State <u>Jean Denney (wife)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory 8/1/2008 Winfield, MD 21. Signature of Funeral Service Lice Burrier-Queen Funeral Home and Crematory, P.A. Do not enter the mode of cyring, such as cardia yor Respiratoly and iteld, MD 2100 Restinate 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed res 2 1 🗆 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOVE HOUS Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. s after death 1 ☐ Yes 2 Accident 2 No completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CROSSRUADS Dr. Ste 340 OWINGS MILLS, MD 2117 Flavio Kruter, 31. Date filed (Month, Day, Year) State Registrar 2008

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:30 AM Dawson 3 i Dolores 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Charlestown Care Center Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 3 / 1 / 19 2 1 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🛛 F 220-07-5250 87 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2☐ No Director Catonsville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 717 Maiden Choice Lane 21228 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed with.....th and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Staff Assistant Telephone Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Jane Fisher Raymond W. Dawson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 2 Matthews Ct., New Freedom, Pa. 17349 Dennis Meerdter / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1. Department of He Important: if it any injury or o once, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Departion 5 ☐ Other (Specify) 8/1/2008 | Baltimore, Md. Bavview Crematory 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Clostridium Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day o 9 ☐ Unknown م signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 5 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an pate has t autopsy performed 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: filled in by the funera Division (Month, Day Year) or Attending 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after To the Hospital within 24 hours the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 044377 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21228 Maiden Charce Lune, Catonsville Bowlin 711 Deneen MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 4 2008 Registrar

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Maryland	and Mental and Mental is marked (19a. Informant's Name/Relationship (Type, Print)	II.	19b. Maili	•	-	nd Numbe	r or Rura	l Route Nur	nber, Cit	y or Town,	State, Zij	Code)	
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687	the sta	edic		d									1			
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	2 0 5	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown	4∏Pregnant at t 9∏Unknown	ime of death	h 5L	Other (sp	ecify)	-			-	a a a a a a a a a a a a a a a a a a a			
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DIVI	s after (Certif	4 ☐ Homicide determined	28e. Place of Injui	ry - At nome . <i>(Specify)</i>	a, rarm, sti	reet, factory	, OTICO				Town, St.		er or Hur	al Route Number,	
HOSO	viitin a bophea of Avenaning ra within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of niner: On the basis of and manner state	f my knowle examination	dge, deat and/or in	h occurred a	at the tim in my op	e, date an inion, dea	d place, a	and due to the	ne cause e, date a	(s) and mand place,	anner as s and due t	tated. the cause(s)	
Tothe	within 2.	Med	29b. Signature and title of certifier	and mariner state)		. License							Day, Year)	
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6	{ '		30. Name and address of person who	completed cause of de		3a) (Type, 441	S. E	LLW	00P	AUE:	BA	LTIN	ount.	MD	21224	4
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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 2109 Amelia Edwards AUGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE A GNES HOSPITAL Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1 M X F Months Days Hours Min. Director 84 29 24 Trinidad 220-27-6001 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show traumatic event, the Medical Exeminer must be notified at Director 1 □Yes 2√2 No MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 4701 Vancouver Road 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify: þ 3 ₩ Widowed 4 Divorced Black "natural" Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event. It is 12th grade Seamstress Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hardy Wilkes Adeline Hardy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Cruickshank-Daughter 4701 Vancouver Road, Baltimore, Md 21229 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition X Burial 2 ☐ Cremation 3 ☐ Removal from State San Fernando 8/9/2008 4 ☐ Donation 5 ☐ Other (Specify) Clements Trinidad 21. Signature of Funeral Service Licensee March Eddyess of Facility 21215 4300 Wabash Ave, Baltimore, Md 23a. Par 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirtk, or heard silure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEP813 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) xaminer GRAFT NFECTED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) SEVELE ANEMIA Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 T Ectopic pregnancy in the past 12 months? Day Month Year I □ Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy performed? /es 2 No certificate 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospina. Within 24 hours after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P23269 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (JUEORBUIEV ANTON 2. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 4 2008 A STATE OF S Registrar

FOWARDS,

Brandon 08-05784	EV	Please Type or Print in Black Indelible	Ink. Ensure All Copi	es Are Legible.	
JNK UNK		State of Maryland / Department - For State Certificate		lygiene	2008 2489
Physici		Registrar 1. Decedent's Name (First, Middle Last)		Reg. No. 2. Date of Death	3. Time of Death
Medical Exami	ner	Brandon Eveline		July 28, 2008	Year 2155 hrs
5 " "		Facility Name (if not institution, give street and number) Johns Hopkins Hospital	4b. City, Town, or Location of Deal Baltimore	m 46. Co	N/A
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24H Months Days Hours Mi		Foreign
Director		220 -0 4-6777 1	Yrs. Days Floars In	11-20-198	3 Country) MA
' any	ŀ	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
/land -f show	ē	Ma. NA	10f, Zip Code	I 100 Citizen	1 VYes 2 No of What Country?
he Mar or 28a ified at	Director	5217 Ken; Worth Are	21212	109. 01.12011	USA
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Funeral		Was Decedent of Hispanic Origin? () If Yes, specify Cuban, Mexican, Puer		Race - American Indian, Black, White, etc.
ler deati ", or ite		1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 \(\subseteq \text{No specify:} \)		BLACK
2 hours afl "natural"	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	dent's Usual Occupation (Give kind o		of Business/Industry
)36 hin 72 h e. than "n edical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Crak	, 15	eurger king
11215-0036 Id be filed within 72 hours after Aental Hygiene "natural", arked other than "natural", event, the Medical Examiner		17. Father's Name (First, Middle, Last)	2	ne (First, Middle, Maiden Sur	name)
ID 21215-003 should be filed withing and Mental Hygiene. T is marked other the mader of the Medice o	To Be	19a. Informant's Name/Relationship (Type, Print)	iling Address (Street and Number o	r Rural Route Number, City o	r Town, State, Zip Code)
mD 2 and 2 shou lealth and N tem 27 is n		19a. Informant's Name/Relationship (Type, Print) Lectrice C. Eveline mom 52	17 Clar / Kenila		acto ind, 2, 12, 12
□ _ □ .		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	position (Name of cemetery, r other place)	Date 20c. Loca	ation - City or Town, State
Itimor it. Pages l irtment of l ortant: If		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	2. Name and Address of Facility =	308 Ca	tonsville, mD.
Balti permit. Departm Imports		laury m. Careline	Jances m. wall	Q20 F.J. 30	eeto, nd 21229
Physician /Medical		20a. Part I. Enter the disease, or complications that caused the death. Do not enfailure. Listonly one cause on each line.		or respiratory arrest, shock,	or heart Approximate Interval Between Onset and Death
⊂xaminer		Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wounds (2) Of The Ci	nest And Abdomen		Deatti
	L	Sequentially list conditions,			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
recuted	Еха	events resulting in death) Last Due to (or as a consequence of): d.			
oe exectician ar	dica	UNPENDED AMENDED	-		
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execut. After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial - tran	sician/Medica	IF FEMALE: 23b. Was decedent pregnant in the 2.3c. If yes, outcome of pregnancy	Fetal death 3 Ectopic pres		onth Day Year
OX 6: ath cert attendii	sicia	past 12 months? 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	Other (Specify)		
O. B at the de 1 by the	Phy:	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?
S, P.O. uires that the signed by d be detach	ed by			-	lo 3 Probably 4 Unknown
cords law requals been a shoul	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital Rec ysician: The his certificate director, page	Con	25. Was case referred to medical	26.Place of Death (Che	1 Yes 2 No	1 Yes 2 No
Vital ysician his cert	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpa	Other	sing Home 5 Residence	e 6 Other:
	- 1	27. Manner of Death 28a. Date of Injury 28b. Time 1 Natural 5 Pending Juli (Month) Day (Pear) 2130 hrs		28d. Describe how injury Subject was shot	occurred
Sion Attender or death rector: by the	icatie	2 Accident Investigation 28e. Place of Injury - At home, farm.	1 163 2 110	28f. Location (Street and	Number or Rural Route Number, City
Divi	Certification:	4 V Homicide Could not be determined (Specify) Local Street		or Town, State) 1900 East North Avenu	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death card to the Trans after death card of the Trans after this certificate has been signed by the attending physician an completely filled in by the funeral director, page 2 should be detached for use as the burial - tr		29a. Certifier (Check only one) 2 Medical Examiner:On the basis of examination and/or inves	ccurred at the time, date and place, a	and due to the cause(s) and n	nanner as stated.
To the To the comp	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		te signed (Month, Day, Year)
	-	Paned Brothall no	O.C.M.E.	July 3	0, 2008
2		30. Name and address of person who completed cause of death (Item 23a)	111 Popp Street Beltimes-	MD 21201	
$\mathcal{L}_{\mathcal{L}}$	tate	Pamela E. Southall, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year)	111 Penn Street, Baltimore	, IVID 2 120 1	
Regis		AUG 0 4 2008 Aces & Spe	M. 3		
DHMH 17 Rev 1/	2001	ÖRIGI	NAL	DOME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene perMD g882 8/4/08 This is a permonent of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician 2008** 6:43 AMM John David Fox July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminster Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F Hours 77 Director 215-28-2508 April 25, 1931 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director MD Carroll Sykesville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 3 Klees Mill Rd. 21784 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 No 1950 -If Yes, Give Year or Dates: 1953 Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛛 No Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hyglene. Douctant: If Item 27 is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Telephone Lineman</u> Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvin Fox Sadie ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Fox (wife) <u> 3 Klees Mill Rd. Sykesville, MD 21784</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State NBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet Cem 8/4/2008 Owings Mills, MD 21. Signature of Functor Service 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of bying, such as cardiax or respirato warrest, i.e.d., DM arrest, DM arrest, i.e.d., DM arrest, i.e.d., DM arrest, i.e.d., DM ar Immediate Cause (Final disease or condition resulting in death) mo **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician are the burial-t Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as t IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use ontribute to the cause of death? Be Completed by No 3 Probably 4 □Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate ha autopsy performed? 1□ Yes 2□No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence & Other (Specify) Hospice 1 Tes No. Certification: To 1 Inpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Villaural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death. To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

30. Name an 4 a

31. Date filed (Mo.

ted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2008 Month **Physician** ELSIE P. FOWLER 29 July 4:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Baltimore-Washington Medical Center Anne Arundel 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 🗓 F 217-18-2951 84 30. 1923 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits men ar is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Example in our mat be profilled at Pasadena Maryland Anne Arundel 1 ☐ Yes 2 HNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 200 East Chestnut Street 21122 Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 □Yes 2 No Black, White, etc 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, It is Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Merchandise Store Order Filler 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Alfred Milton Fowler Lillie May Lewis ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 200 East Chestnut St., Pasadena, Md. James A. Fraley (Great Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 8/1/08 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Kevin E. ²² Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Md. 2 Approximate Interval Between Onset and Death 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. n each line. Immediate Cause (Final Den **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) s been signed by the should be detached g \square Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page ; certificate 1 ☐ Yes 2 🖾 No 1 ∐Yes 2 MaNo this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Monatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 **⊠**Natural 5 Pending investigation Within 24 hours arter occur.

To the Funeral Director: After a completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenes 22 5 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 AUG 0 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AND THEFT, perff. 882, 8/4/08 W.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:12 A M 2008 her /Medical nstitution arive street 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore
Under 1 Year | If Under hristian are HSS st. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Funeral 9 Days -26-1509 1 ☐ M 2 🕶 F Months Min. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show or Items 23a or 28a-f sk aminer must be notified 1 ☐ Yes 2 No Director rino 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? rive USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 □ Divorced 'natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.] once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr Glive kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Johnson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) BigSpring 619 200ames baither lor 20b. Place of Disposition cemetery, cremator 20a. Method of Disposition ocation - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) atonsv:1 21. Signature of Funera Service reine 23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearthallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1755 **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the burla IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🔲 Yes 2 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2∏ No 1∐ Yes 2 No ☐Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Spec 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, AUG 0 4 32. Registrar's Signature 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Louise Glorioso 2008 /Medical Aug. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium Baltimore Lorien Mays Chapel N.H. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2-23-1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Maryland **Funeral** 1 □ M 2 🔏 F 90 Yrs Director 213-09-3803 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
The size is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 20a or 20a-f show any or other traumatic event, ITE footies Exeminer must be redified at any or other traumatic event, ITE footies Exeminer must be redified at Director Baltimore Timonium 1 ∏Yes 2 X No Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 U.S.A. 12230 by Funeral Roundwood Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 TNo Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Loan Officer Social Security 9th Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tagliaferri Julia Testa ဥ Everest Taglifferr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arcangelo Tuminelli - Son 1245 Berans Road Owings Mills, Md. 21117 permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht of Jesus8-6-2008 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Home 263 S. Conkling St. Balto. MD. 212 1.1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMENTIA **Physician** 512M25 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-tran The law requires that the death certificate be exect Due to (or as a consequence of) Box 68760; physician Physician/Medical the attending p as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) o the a detached 9 Unknown 9 I Unknown ۵. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by þe HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 1 □Yes 2 🖪 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Man or of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number
29d. Date signed (Month, Day, Year)
Aucust 4, 2008 29b. Signature and little of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21043 TULLMORE RO. TIMONIUM ERIC Corre no 12221

Registrar

State

31. Date filed (Month, Day, Year)

AUG 0 4

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 0 8

24896

						Certificate of	f Death	Re	g. No.	00 2	24030
	Physici	an	Decedent's Name (First, Middle, Le		0. 1			July 27	, ^D 27008		Time of Death
	/Medi		Richard	Vincent	Gled	raitis			1		:50 pm
d.	Examir	ner	4a. Facility Nam <i>e (If not institution, giv</i> Charlestown Car				4b. City, Town, or I Catonsvi	.11e	4c. County Baltin		
	Funeral Director		5. Social Security Number 6. 8 218-12-7128 Usual Residence of Decedent	15 M 2□ E	(In yrs. last bir	thday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day, June 27	, 1924	9. Birthplace Country! Mary1	(State or Foreign and
	yland		10a. State 10b. County		10c. City, Tow	n or Location				10d. li	nside City Limits
	e Mar	cto	Maryland Baltimo	re	Caton	sville				1	☐ Yes 2 No
	th with th	al Director	10 <i>e.</i> Street and Number 719 Maiden Choic	e Lane HR	546	10f. Zip Code 2122		10	og. Citizen of V USA	What Country?	
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23a or 28e-f show may highly or other treumatic event, the Medical Examiner must be inclined at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	lo	13. Was Decedent of If Yes, specify Cu	ıban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Blac	e-American Inck, White, etc. White	
Maryland 21215-0020	ithin 72 ho ne. nen "netur e Medical	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5		Decedent's Usual Occ (Give kind of work don life. DO NOT use retii	e during most of wor red)	king		usiness/Industr	1
2	fled w her th	3	12 17. Father's Name (First, Middle, Last,	1		Flectron	ic Technic	cian ne (First, Middle, M	Westing		
ylanc	should be filed withind Mental Hygiene. I marked other then umatic event, ILE M	To Be	Vincent		Giedra		Mary		(Unkno	wn)	
, Mar	and 2 sho salth end 1.27 is me er treum		Noreen A. Giedrai	**		Mailing Address (Stree 9 Maiden C					
Baltimore,	Pages 1 nent of He nt: If item iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemeter	Disposition (Name of y, crematory or other p				City or Town,	
	t. Pag tment tant: jury o		4 ☐ Donation 5 ☐ Other (Specify	y)	Meadow	ridge Memo					
g	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	1See	And the second s		ress of Facility Lot kens Ave.				
			23a. Parti Enter the disease, or com Shock, or heart failure. List only	plications that caused	the death. Do r						roximate
Ta	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	a. Mer	tasla		inal ce	_		Ons	rval Between set and Death
,	executer n end iel-trans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	Due to (or as a o	consequence of):					
x 68/60,	erlificate be executed ding physician end se es the buriel-transit	Medical	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a c	onsequence of):					
, P.O. Bo	r requires that the death certificate be executed been signed by the ettending physician end should be deteched for use es the buriel-transit	by Physician	Part II. Other significent conditions o	ontributing to death bu	t not resulting in	n the underlying cause (given in Part I.		oacco use cor s 2⊡ No		ceuse of deeth?
ecords,	N S S	Completed b						24a. Was en perform	autopsy ed?	aveilabl	utopsy findings e prior to tion of cause 1?
r	The ete h page	Com						1 □ Ye	s 2·□ No	1 ☐ Yes	s 2□ No
VITal V	Physicien: The this certificete ral director, pag	Be	25. Was case referred to medicel examiner?	Hospital		16		th (Check only one)		
5	this aldi	: To	1 ☐ Yes _2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatie		tpatient 3LI DOA		ome 5 Resider 28d. Describe how			
DIVISION	ending seth. or: After the fune	Certification:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day	Year) Ir	njury W M 1	Yes 2 No				
2	5 £ £ 5	Certifi	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, fa . <i>(Specify)</i>	rm, street, factory, office	9	28f. Location (Str. City or Town,	eet and Numb State)	er or Hural Hou	ite Number,
	To the Hospital or within 24 hours efft or To the Funeral Dir completely filled in	edical			examination and	, death occurred at the dor investigation, in my					
	.)	Me	29b. Signature and title of certifier Auc	wooda	in M.		nse number 22/04/2		d. Date signed	d (Month, Dey,	Year)
S	317		30. Name end address of person who	? The	194 1	Type, Print)	2041 Cale	elle p	18	7/	225
	Sta Registr		31. Daté filed (Month, Dey, Year) AUG 0 4	2008 32. Applish	rs Signeture	Spele					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10:40 PM July 3 DEVONNE HELEN HOLLINGSHEAD 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore washing ton Social Security Number 6. Sex medical Center Arundel If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number (In yrs. last birthday **Funeral** 1□ M 2 🗹 F Days Months Hours Min 89 180-10-5115 Director FEBRUARY 18 1919 PENDSYLVANIA Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Example or other traumatic event, the Medical Example or other traumatic event, the Medical Example or other traumatic event, the Medical Example or other traumatic event, the Medical Example or other traumatic event, the Medical Example or other traumatic event, the Medical Example or other traumatic event. 1 ☐ Yes 2 ☑ No Director MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 91952 USA SOUTHERLY ROSD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify 2 Specify: 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSE WIFE (i) (i) 10 40 Vingshead laryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MABLE HOLLINGSHEAD CLINTON HULLINGHEAD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOUTHERLY DOAD! COMPAH ATTT /DAUWHTER BALTIMONE ms 31332 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State MANJUAN, ANGLAND 4 Donation 5 Other (Specify) ARDENT LIVE MATRICE AULUST 4 DOOD Signature of Funeral Service Licensee 22. Name and Address of Facility ARAGUS CREMATIO 7522 CONJECUSY Dr. SIZE NO. HONDUR MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vanced /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? autopsy page performed this certificate 1 ☐ Yes 2 ☑ No 2 1 NO 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) gorge 41365 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Ev 301 Hospital Drive, Glen Burnie, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State park 2008 4 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Seasons Hospice Randallstown | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | May 16, 1934 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 ☐ M 2 ☐ F Months Tenn. 74 413-50-7228 Director Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-4 shov any Injury or other traumatic event, the Medical Examinar must be institted at Director 1 ☐Yes 2 No Baltimore Owings Mills Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21117 15 Old Tollgate Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No ģ Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Gollege (1-4or 5+) Elementary/Secondary (0-12) Security State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Guss B. Hylton Helen M. Chain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Ruth Hylton - wife 15 Old Tollgate Rd. Cwings Mills, MD. 21117 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Cem. A 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 6, 2008 Baltimore. MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lcthardt Tuneral Chapel F.A. . Hart Elleto 11605 Reisterstown Rd. Owings Mills, MD. 21117 23a. Part 1. Enter the disease, or complications that caused the cath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-trans and Due to (or as a consequence of) attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I the a 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 【XNo 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy performed's The 2 No 1 ☐ Yes 1 □Yes 2 Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HSSPILE 1 ☐ Yes 🎾 No After this of 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after co...

To the Funeral Director: After connected filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

17

Registrar

10000 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month C 8 Day Year O & Physician HOLROYD RANK 10:58 AM 01 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ge (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 80 Months 1 M 2 □ F 217-20-Director 610 July 11, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show aminer must be notified at Armstead GARDENS 1 XYes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ERDMAN AVENUE 500L 16.5.A 21205 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No Prmy If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BAHIMORE and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) INSULANCE Maryland 17. Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WAHER Pages 1 and 2 should be nent of Health and Mental FRANK 5 pouse 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau 5008 MD 21205 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriat 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hug 2, 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CONKLING St. Cart1 mplications that caused the death ly one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) **Physician** UL MONOY 4 cm bed 15 m /Medical 1 hour Examiner Sequentially list conditions, if any, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): signed by the attending physician does detached for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions computing to death but not resulting in the 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ce 29d. Date signed (Month) Day, Year)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a

To the Funeral C

> State Registrar

30. Name and address of fe

31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

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mpleted cause of death (Item 23a (Type, Print)

32 Registrar's Signature

Rowen Blud BAHO

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and 1-For State Registrar State of Maryland / Department of Health and Certificate of Death	Reg. No. 2008 249
Physici al Exami		1. Decedent's Name (First, Middle,Last) Ra(ph Hall	2. Date of Death Month Day Year July 30, 2008 3. Time of Death 0600 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lo	ocation of Death 4c. County of Death
Funeral		4701 Greenspring Avenue Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director		213-78-0779 1 M 2 F 37 Yrs. Months Days	Hours Min. 06-12-197/ Foreign Country) M.D.
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland 28a-f show d at once	ţ	MD. NA Paltmoie	1 Nes 2 No
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ath with tems 23 st be no	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispa	anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
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vithin 7. ene. er than Medical	Comple	12th NA BAIL BONS	DSMan BAIL BONDS
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permit. Pages 1 Department of P Important: If i		Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	u 8-5-08 Catonsville, m.D.
permit. Pag Department Important: injury or ot		21. Signature Funeral State Ucenses 22. Name and Address of	FFICILITY 270 FredHILTON HOSS
ysician	S 13	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mobe of dying, su failure. List only one cause on each line.	
Medical caminer	9 70	Immediate Cause (Final disease a. Gunshot Wounds (2) of Torso	Between Onset and Death
		Due to (or as a consequence of): Sequentially list conditions, b	
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eath certificate attending phy for use as the b	Physician/I	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
nat the d of by the etached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I. 23e. Did tobacco use contribute to the cause of death?
quires that en signed ald be deta	ted by		1 Yes 2 V No 3 Probably 4 Unknown
e law re e has be e 2 shor	Completed		24a. Was an autopsy findings available prior to completion of cause of death?
certificate	Be Co		1 ✓ Yes 2 No 1 ✓ Yes 2 No f Death (Check only one)
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or Atte after de Directo	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office build	lding, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide	4701 Greenspring Avenue, Baltimore , MD
n 24 n 24 ne F	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, defined and manner stated.	
om thi	š	29b. Signature and title of certifier 29c. License n O.C.M.	, , , , , , , , , , , , , , , , , , ,
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To the within To the comp		1 pm / wasself, 10	
To # vithi vithi To # Comp	A111	30. Name and address of person who complited cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Bali 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

OCME 2006

08-05841 Arthur Holley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 30, 2008 Year Arthur Vincent Holley 1555 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Regional Hospital Randallstown **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 217-40-9933 Director 12-14-1941 MD 1 X M 66 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Baltimore Pikesville MD death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' USA 21208 7400 Rock Ridge Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 X Married Yes Specify: African-American Give Year 1965-70 hours after Widowed Divorced Yes 2 X No specify: <u>\$</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 I nent of Health and Mental Hygiene. If item 27 is marked other than her tranmatic event, the Medical 21215-0036 General Motors 12th Assembly Line Worker 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Majden Surname) Be Arthur Hollev Martha Bankhead 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MDM Gloria L. Holley/Wife 7400 Rock Ridge Road, Pikesville, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 Cremation Removal from State Department of Important: I injury or oth Garrison Forest Veterans 8-7-08 Other Specify: Owings Mills, MD 22. Name and Address of Facility While Funeral Home P.A. of Balto.Co. Simulture of Funeral Service License 9200 LibertyRoad, Randallstown, MD 21133 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED ending physician use as the burial AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery . Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify, Yes 2 No 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Completed Division of Vital Records. 24a. Was ar 24b. Were autopsy findings available prior to completion of cause of death? autopsy has performed? ✔ Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 **V** ER/Outpatient DOA this Residence 6 2 1 V Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: ✓ Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Pending Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 31, 2008 Wi 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 2008 \$2. Registrar's Signature State BAR. Barrell ... Registrar

DEIVIN 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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1	ŀ	30. Name and address of person wh	o completed cause of d	eath (Item	23a)	L							
4		Theodore M King Jr N	~			1 Penn S	treet Ralt	impre MD 2	1201				

Registrar

DHMH 17 Rev 1/2001
OCME 2006

31. Date filed (Month, Day, Year)
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32. Registrar's Signature

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	/Medi			HAMLII									008	3:3	2A M
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Leg Park	Funeral		5. Social Security Number 6. Sec		7. Age (In yrs.	last birthday)	If Under	WSO 1 Year	IN If Under 2	24 Hrs.	8 Date of Bir		ALTIMO	RE hplace (State	or Foreign
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jefferson 16:25 Loper August Shirley /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Sina: Ho 20 Baltimore 13 altimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 99 09 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M **X**□ F 196-26-4012 PA Director 76 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at Baltimore Director 1X Yes 2 No NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 3706 Columbus Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Ś Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bank Banker 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fill and Mental H Be Eva Marie Cummings John Wesley Loper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2.
Department of Health a important: if item 27 is any injury or other trau George Jefferson Jr.-Husband 3706 Columbus Drive, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 8/11/08 Owings Mills, Md atura of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mine diate Cause (Final mease or condition resulting in death) **Physician** 1 day Se. 17515 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissass of injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of) burial-Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death P.0. 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe certificate 1 ☐ Yes 2 ☑ No 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) After th funeral 27. Magner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🗹 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number RES-600 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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31. Date filed (Month, Day, Year)

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Registrar's Signature

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Hospital of Baltimore

Division or Vital Records, P.O. Box 68760,

> State Registrar

29b. Signatur

MICHAEL 31. Date filed (Month, Day, Year)

and title of certifie

Mul

29c. License number

OLD COURT ROAD RANDAUSTOWN

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROTHKIN

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32. Registrar's Signature

Amend #5, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2008 5:25 P ^M August D. Johnson, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Linthicum Heighte If Under 14 Hrs. | 8. Date of Birth (Month, Day, Year) August 18, Anne Arundel 11 Eleanor Avenue 5. Social Security Number 212 218 20 - 3777 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Maryland 1**X** M 2 □ F 1926 81 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County if than "natural", or items 23a or 28a-f show 1 □ Yes 2 No Director Maryland Linthicum Heights Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21090 11 Eleanor Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1▼Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by Specify: 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, It also Elementary/Secondary (0-12) College (1-4or 5+) Postal Service Letter Carrier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnson, Sr. Josie Lee Leo ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 Eleanor Avenue Linthicum Heights Maryland 21090 Patricia Hall Johnson (Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date H Burial 2 ☐ Cremation 3 ☐ Removal from State 08/06/08 Cedar Hill Cemetery Brooklyn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mccully-rollyniak Funeral Home, P.A. 237 East Patapsco Avenue Baltimore Maryland 21225 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mile of dwing, shock, or heart failure. List only one cause in each line. such as cardiac or respiratory arrest, pproximate derval Between Inset and Death Immediate Cause (Final **Physician** my disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mo Month Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed death? certificate 1 □ Yes 2 🗗 25. Was case referred to mancal examiner? 26. Place of Death (Check only one) Be To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the first Hospital: Other: 4 Nursing Home 5 Desidence 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☐ Other (Specify) Medical Certification: To 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Division 1 Un atural 5 Pending 1 ☐ Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier se of person who completed cause of death (Item 23a) (Type, Print) (M) LUCL 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Wilbur J. 30 Jully 2008 Keeton Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Perring Parkway Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 1 X M 2 □ F 81 Virginia Director 04/11/1927 228-30-1694 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or Items 23a or 28a-f shov Examiner must be notified at 28a-f show 1X Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 1801 Wentworth Road U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after ☐Yes 2 f Yes, Give 2 X No 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No 9 3 XWidowed 4 ☐ Divorced Year or Dates "naturai", Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill Laborer 10 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H tem 27 is marked oth Be ٩ Lula Keeton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 North Pulaski Street, Baltimore, Maryland 21223 Wilbur J. Keeton Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or ot 08/06/2008 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland Meadow Ridge Cemetery 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service License 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner be executed burial-trar and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 cate has been signage 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2**X** No 1□ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral D 1 🛛 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) D53682

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32 Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 723PM 054 KEI 1,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMOR If Under 1 Year | If Under 24 Hrs. BALTIMORE 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 10.9.1935 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🖳 Months Days Hours Director NC Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Health and Mental Hygiene. sem 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Widdon Exact or at a continual Baltimore Director 1 Pres 2 No 10e. Street and Number 10g. Citizen of What Country? Montpelier Street 21218 U.S. A 1610 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ NO Specify: <u>م</u> Black 3 Vidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Atkinson Everett ပ laymond Helen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr. once. hery 1610 Montpelier St. Baltimore, Mi) 21218
of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8.4.2008 Baltimore, MI 4 ☐ Donation 5 ☐ Other (Specify) Zion 21. Signature of Funeral Service Lice 22. Name and Address of Facility Vougnn C. Greene Funeru Services Vaughn C. Sheene 4905 York Rd Baltimore, I 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached in Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □Yes 1 ☐ Yes Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Yes 2 No 2 R/Outpatient 3 DOA 1 Inpatient After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, 28h Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Natural To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: Α completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ddress of person who completed cause of deat (Item 23a) (Type, Print) ERITH

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** GORPON AUGUST KIDWELL 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HARBOR HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 MARYLAND 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 84 Months 1 □ M 2 □ F 19 1924 212-20-3997 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 XYes 2 No MD BALTIMORE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 16th AVENUE 21225 308 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No If Yes, Give "natural", or Items 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify. Specify: WHITE If Yes, Give Year or Dates: WWII Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4or 5+) BUILDING INSPECTOR SUPERVISOR s 1 and 2 should be filed w f Health and Mental Hygier Item 27 is marked other th other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM HENRY KIDWELL MAY SCHRIVER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, MD 21225 308 16th AVENUE CHARLOTTE JACORSEN friend or other 1 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
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any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 2008 BROOKLYN, MARYLAND CEDAR HILL CEMETERY AUG 22. Name and Address of Facility MCCULLY POLYNIAK FUNERAL HOME 21. Signature of Funeral Service Licenses PA 237 E. PATAPSCO AVE. BALTIMORE, MARYLAND 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG **Physician** CANCER METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending nse : 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed Yes 2 No certificate has page 2 1 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☑ Inpatient 1 Tes 2 ER/Outpatient 3 DOA ၉ this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h. Time of 27. Manner of Death 28c. Injury at Work? Certification: After Hospital or Attending I 24 hours after death. Funeral Director: After 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUGUST 2008 MO RES 000

State Registrar

ar 31. Date filed (Month, Day, Year) AUG 0 4 2008

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ST BALTIMORE
32 Begistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHANIE KAHN7RCFF

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 **Physician** Helen Agnes Kirby 1:18 PM 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saluare osedale Baltimore Franklin Hospita Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number If Under 1 8. Date of Birth (Month, Day, Year) 02-17-1920 7. Age (In vis. last birthday) **Funeral** Months Days Hours Min Penns lyvania 1 M 200 220-12-7761 88 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Acted Exercise. Director 1 ☐ Yes 2 ☑ No MD Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 33 Old Knife Court 21220 U.S.A. 人」でして、 けんしん Baltimore, Maryland 21215-0036 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ∑ No Specify. Specify. 3 DLWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Terrance Palmer Pauline McDowell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen James / Daughter 1906 Lindemann Ln., Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □Other (Specify) Dulaney Valley 08-06-2008 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signatura of Funeral Service Licen ee 1050 York Road, Towson, Maryland 21204 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arrhythmu **Physician** atal minutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

uneral Director: After this certificate has been signed by the attending physician and ly filled in by the funeral director, page 2 should be detached for use as the human. Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 1 ☐ Yes 2 🗷 No 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by hyper tension hibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 図 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 54702

Registrar

State

DHMH 17 Rev 1/2001

Baltmore MD

O Franklin Square Drive 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000

Dr. Nona Novello

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No. 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yea **Physician** 930 /M ora 1008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number). 4c. County of Death Examiner OAKCREST VILLAGE CARE CENTER PARKVILLE BALTIMORE Date of Birth (Month, Day, Year)
MAY 26,1923 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Numbe 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 85 068-12-8659 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No MD PARKVILLE BALTIMORE 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 8800 WALTHER BLVD #1107 21234 USA Funeral should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 □ If Yes, Give Year or Dates: 2 🗆 No 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3K Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12 College (1-4or 5+) ELECTRICAL ELECTRICIAN-MANAGEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE KINGMAN MABEL BETTS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8516 GRADIEN DR BALTIMORE, MD 21236 Department of Health an Important: If item 27 is many injury or other LESLIE KINGMAN-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ATLANTIC CREMATORY 8/5/08 GLEN BURNIE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 23a. Pa 11. Filler the lisease or o shock, or heart fillure. List o mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent Physician/Medical Examiner certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? 1 ☐ Yes 2□ No 1∐ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 ☐ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 ulli Md 21234 ALCE sucuth 8800 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008

1- For State Amend #5, perFH G882 8/13/08 The Certificate of Death

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 30 2008 **Physician** 10:50 PM Leonard Wayne Logue /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster 4131 Salem Bottom Rd. Trunder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year NOV 18, 1 9. Birthplace (State or Foreign 212-40-5821 217-90-78 7. Age (In vrs. last birthday) **Funeral** 1 € M 2 🗆 F 66 1941 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State show th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Medical Examinat must be notified in 1 ☐ Yes 2 No Director MD Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4131 Salem Bottom Rd. 21157 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣
If Yes, Give
Year or Dates: 1 Never Married 2X Married 1 □Yes 2**XX**No Specify: White Baltimore, Maryland 21215-0036 ð 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Operator 2 Carroll CO Roads 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Russell Loque Erma Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau 4131 Salem Bottom Rd. Westminster, MD 21157 Clarice Logue (wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition **X**Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem Park 8/4/2008 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 22. Name and Address of the Surrier Address o 21. Signature of Funeral Service Licenses Burrier-Queen Funeral Home and Crematory, P.A. ode 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Meta VPUL **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan; The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) has been signed by the e 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate ha 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To ₽ After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident Director; of in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Manchester Rd Manchesta MD 2110 Sr. MM 297 Year) 32. Registrar's Signature 31. Date filed (Month, Day, State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month AUGUST 12:40 AM 2000 LORENE LASSITER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE N/A UNION MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, MAR • 3 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days Hours Min. Months T929 1 ☐ M 2 🖳 F 79 213 26 6072 NORTHCAROLINA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County No Yes 2 No BALTIMORE MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 USA 1419 N. BOND ST. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕍 No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOME 4th HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LULA LONNIE MANNING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1419 N. Bond St. Balto, Md. 21213 ANDRE WILLIAMS (nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State AUG.6,2008 BALTIMORE,MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Ignature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO MD. 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 15 DAYS PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of): UTI 15 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): MONTH S RENAL FAILURE Due to (or as a consequence of): YEAK ADVANCED. DEMENTA IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZNo Month Year 4 Pregnant at time of death Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐Yes 2 ☐No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

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Pages 1

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

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Examiner Physician/Medical Completed Be Certification: To funeral (ne Hospital or Attending Pin 24 hours after death. To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

State

Registrar

Medical

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ani kulkami

29c. License number AT 2438946 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 201 E. UNIVERSITY PARKWAY, UNION MEMORIAL HOSPITAL

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

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To To com	and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)													
			(01/	1/				O.C.N	Л.E.			ust 3, 2008	
15/1	1	30. Name and address												
		Jack Titus MI		uty Chief	Medical E				et, Balt	imore, MD 2	21201			
Sta Regista		31. Date filed (Month		2008	A Registra	o Signal	Son	age of						

08-05915

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 State Registrar Amend 29d, perMD, G882 8/4/08Centificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 45PM Millie Macklin 2008 July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 T Director 238-70-0141 64 24 NC 10 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene. show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes 2 🕅 No Directo 28a-f DE Dover 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or 19901 Funeral 690 Roberta Ave U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No \$ Specify. 3 ☐ Widowed 4√ Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade <u>6yrs</u> Social Worker State of New York 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John P. Perry ည Mary A. Arrington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MD 21133 RandalIstown, Health: Phyllis Price-Niece 9707 Branchleigh Road, Apt 2, permit. Pages 1 a
Department of Her
Important: If Item
any Injury or othe 20a. Method of Disposition Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State St. Stephens Baptist ☐ Donation 5 ☐ Other (Specify) Church Cemetery 8/2/08 Warrento
22 Name and Actives of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md Warrenton, NC 21. Signature of Funeral Service Licensee 21215 23a. Pert 1. Enter the disease, or complications the hock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest each line. Approximate Interval Between Electrical Activity
ance of:
status epilephicus Onset and Death nediate Cause (Final Physician Pulseless isease or condition /Medical resulting in death) Examiner Nonconvulsive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) y physician and as the burial-trans Due to (or as a consequence of) ivision of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the att 5 Other (specify) Yes 2 No 9 Unknown 9 > Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 → No 3 □ Probably 4 □ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 2 No 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 🗷 No 1 🗷 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending F after death. 1 Natural 5 Pending investigation Injury 2 Accident 1 🗌 Yes 2 🗆 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🗷 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital within 24 hours a To the Funeral D

State Registrar

31. Date filed (Month, Day, Year) 2008 AUG 0 4

Thaku

29b. Signature and title of certifie

Kiran

3. Registrar's Signature

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

June 24,2008

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\Omega\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 20 M /Medical Facility Name (If not institution, give street and number) , or Location of Death County of Death **Examiner** Kaltimore umm Birthplace (State or Foreign Country) **Funeral** 1**A**M 2□ F Director Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heatht and Mental Hygiene. ortant: If iten 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, it. Predict Exp. in traum to a refined at 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USF Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. □Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working plife. DO NOT use retired) College (1-4or 5+) 17. Father's Name (First, Middle, 18. Mat Be er's Name (First, Middle, Maiden Surnan Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department o Important: If any Injury or once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Kalto. 4 ☐ Donation 5 ☐ Other (Specify) Funeral Services 21. Signature of Funeral Service Licensee laughn C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumanic /Medical resulting in death) e to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to for 35 a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) O. Box 68760 Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown ۵. Partyll. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a, Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Director; filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 | edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) rson who completed we of death (Item 3a) (Tipe, Print) 30. Name and Day, Year) 32. Registrar's Signature State 4 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 1722 7 **Physician** Medaugh rederick 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Bay weren Medical Lenter Baltemore Hopkins If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2 □ F Months Days Hours 68 Director 213-38-5167 New York 11-18-1939 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show 10b, County 10c, City, Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exeminar must be notified at Baltimore City Y☐Yes 2☐No Director Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 USA 3647 Dudley Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Balto. City School Board Carpenter 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked ot Eva E. Witt Frederick W. Medaugh, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3647 Dudley Ave. Balto. Md. 21213 19a. Informant's Name/Relationship (Type. Print) Health a permit. Pages 1 and Department of Health Important: If item 27 any injury or other tra Jacqueline Medaugh Wife 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-1-2008 Balto. City Bayview 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Home terrie 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Premonta Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown nis certificate has been signed director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an 2. No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After **Hospital or Attending** 5 ☐ Pending investigation Natural Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifler 1 🔁 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

4940 EASTON ALENE BALTIMORS MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Brian Howard M.D.

AUG 0 4

31. Date filed (Month, Day, Year)

The state of Maryland / Department of Health and Mental Hygiens (Certificate of Death Reg. No. 0) { Physician / Medical Examiner Aa. Facility Name (If not institution, give street and number) 7713 Suitt Drive Pasadena Anne A S. Social Security Number 219–18–7598 State of Maryland / Department of Health and Mental Hygiens (Reg. No. 0) { Peg. No. 0 { Certificate of Death Month O7 Day Month Nonth O7 Day Month Day Peg. No. 0} 4b. City, Town, or Location of Death Anne A Pasadena Anne A S. Social Security Number 219–18–7598 S. Social Security Number 219–18–7598 S. Social Security Number 219–18–7598 S. Social Security Number 32 Funder 1 Year If Under 14 Hrs. Month Day	eath
Physician /Medical Examiner Physician /Medical Examiner 4a. Facility Name (If not institution, give street and number) 7713 Suitt Drive Pasadena Month 07 94 4c. County of Death Pasadena Anne A	95 1031 A M
Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 7713 Suitt Drive Pasadena Anne A	eath
7713 Suitt Drive Pasadena Anne A	rundel
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month Day Year	
Director 219–18–7598 1 SM 2 F 82 Yrs. Months Day's Hours Min. Mar. 14 1926 M	Birthplace (State or Foreign Country)
Usual Residence of Decedent	aryland
	10d. Inside City Limits
Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What 218 Clen Road 21122 115A	1 ☐ Yes 2 ☐ No
10a. State 10b. County Maryland Anne Arundel Pasadena 10e. Street and Number 218 Glen Road 11. Marital Status 11 Never Married 2 Married 1 Mary are of Dates: 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A Black, W. 15. Decedent's Education 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busine (Give kind of work done during most of working life. Do NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 19. Citizen of What 21122 USA 19. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify: Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 17. Father's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame)	: Country?
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 11. Never Married 2 Married 1 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, W	merican Indian, Vhite, etc.
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(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	our noustry
Truck Driver May Co.	
10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10d. State 10d. City 10d. State 10d. City 10d. State 10d. City	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Virgie M. Mueller (Wife) 218 Glen Road, Pasadena, Maryland 2112	
20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City	
1 DBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 DBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Md. Veterans Cemetery 8/4/08 Crownsvill	le, Maryland
1 Deurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 Deurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fundral Service Licensee Kevin E Ecker 22. L. Patapsco Ave., Baltimore, Ma	
237 E. Tatapseo Ave., Bartimore, Ad	
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Approximate Interval Between Onset and Death
/Medical // / / / / / / / / / / / / / / / / /	year
Examiner	O
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of):	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
sician be e priis	
Ne se se se se se se se se se se se se se	
23d. Date of Description of the past 12 gronths?	delivery Day Year
IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1	,
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions.	e to the cause of death?
Se la se la partieral Vara diseas à 1040s 20 No 30	Probably 4 Unknown
1946s 2 No 3 De 19	autopsy findings available to completion of cause of
performed? death	h?
U 25. Was case referred to medical examiner? Hospital: Description 25 Place of Death (Check only one) Hospital: Description 25 Place one 25 Pla	ILNIC HODGE
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other 2 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work?	specific tome
1 SANatural 5 Pending (Month, Day Year) Injury Work? 1 Accident investigation M 1 Yes 2 No	
28a. Date of Injury 28b. Time of Injury at Work? 1 Accident investigation 3 Suicide 4 Homicide 4 Homicide 28b. Pending investigation 4 Homicide 4 Homicide 4 Homicide 28b. Pending investigation 28b. Pending investigation 4 Homicide 4 Homicide 28b. Pending investigation 28b. Time of Injury 28b. Time of Injury at Work? 1 Accident Work? 28c. Place of Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28b. Time of Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28b. Time of Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury at Work? 28d. Describe how injury occurred 2bb. Time of Injury at Work? 28d. Describe how injury occurred 2bb. Time of Injury at Work? 28d. Describe how injury occurred 2bb. Time of Injury at Work? 28d. Describe how injury occurred 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 1 Yes 2 No 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work? 2bb. Time of Injury at Work?	r Rural Route Number,
Company of the control of the contro	r as stated. due to the cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (M	Ionth, Day, Year)
JUN 1 Jenta un 1) 21438 Jug29,	2008
39. Name and address of person who combleted cause of death (Item 23a) (Type, Print) WILLIAM WAPPLI) M WAPPLI M W	1021401
State 31. Date filed (Month, Day, Year) 2. Registrar's Signature Registrar 11. C 0. 4. 2008	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland	-	rtment of H			giena 008	24919
£.	Physici /Medic		Decedent's Name (First, Middle, Last,	Kita M	c Cu	rley		2. Date of Dea Month	30 200	J 11-83/FM
	Examin Funeral	er	4a. Facility Name (If not institution, give 5 - 12aleth 1	Jursing Cer	nter ast birthday)		r Location of Deal imore If Under 24 Hrs	8 Date of Birth	4c. County of De	
9	Director		Usual Residence of Decedent	M 250F 80	Yrs.	Months Days	Hours Min	(Month, Day 4/26/19	r, Year)	ryland
	72 hours after death with the Maryland natural', or items 23a or 28s-f show dical Examinar must be notified at	Director	10a. State 10b. County Maryland n/a 10e. Street and Number		, Town or Loo Bal	timore			10g. Citizen of What	10d. Inside City Limits 1 Yes 2 No
	with a or	ក្ន	3835 Wilkens Av	zenue		10f. Zip Code 212	20		United St	·
	death ms 23	Funerai		12 Was Decedent Ever in U.S.	S. 13. V			Specify Yes or No- to Rican, etc.)		nerican Indian,
980	ral', or Rei	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cuba	an, Mexican, Puer Specify:	to Rican, etc.)	Black, W Specify:	white
21215-0036	within 72 h ene. then *natu he Madical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. D	ent's Usual Occup kind of work done OO NOT use retired	during most of wo	nrking	16b. Kind of Busine	
d 2	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last)	2	Hous	ing Coun		me (First, Middle,	Social Maiden Surpame)	Work
Maryland	should be nd Mental marked o	To Be	Daniel Murphy 19a. Informant's Name/Relationship (Ty	na Rriget	10h Mailin	a Address (Street	Ei	leen Kava	,	7 Code
Ma	and 2 sl salth and 7 ls r		Mrs. Mary E. Young			Wilkens		Baltimo:		, 21p Code) 229
Baltimore,	T Te		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. Pla	ace of Dispos	sition (Name of patory or other place rk Cemete	ca)	Date	20c. Location - City Baltimore,	
Balti	permit. Page Department Importent: If any Injury or		21. Signature of Funeral Service License	98		Name and Address Hubbard 1 4107 Will	Funeral :	Home, Inc	C. Itimore, M	D 21229
	Pnysician		23a Part 1. Enter the disease, or compleshock, or heart failure. Lest only of Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. ne cause on each line.	. Do not ente	or the mode of dyin	ng, such as cardia	c or respiratory an	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consequ	ilure	to -	thrive			months
_	xecuted and al-transit	Examine	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	izur	e disc	order			years.
68760,	death certificate be executed e attending physicien and of for use as the burial-transit	ledical B		1						
P.O. Box		Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Date of o Month	delivery Day Year
	The law requires that the ste has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions con	ntributing to death but not resul	Iting in the un	derlying cause giv	en in Part I.	23e. Did to	\d	to the cause of death? Probably 4 □Unknown
Division of Vital Records,	: The law recate has be page 2 sho	Completed						24a. Was a autop perfor 1 \(\supers \text{Yes} \)	sy prior t	
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		Oth	1 -	ath (Check only or		
o	Attending Physician: r death. actor: Atter this certifici by the funeral director, i	J: To	27. Manner of Death	28a. Date of Injury	R/Outpatient 28b. Time of	3☐ DDA 28c. Injun	4 Nursing		ence 6 Other (S	pecify)
<u>0</u>	Attending F death. ctor: After y the funer	atio	1 ANatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □No			
Divis	tel or Attences after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after Geath. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 17 Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occ	e, and due to the ourred at the time, o	cause(s) and manner date and place, and c	as stated. ive to the cause(s)
)	with com	Σ	29b. Signature and title of certifier	then	mo	29c. Licens	e number	91	July 3 (, 200 f
	5'		30. Name and address of person who occurred with the state of the stat	o Benson	Aven	orint)	1timor+	e, Ma	July 3 c	21227
Salar Salar	Sta Registr		31. Date filled (Manth Day, Year) 2008	32 Registrar's Signatu	ure Spar				/	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 200ໍ່ຊື່ 3:15 ДМ Eleanor Elizabeth Michaels August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Holly Hill Nursing Home Towson 8. Date of Birth (Month, Day, Year July 26, 1 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🙀 F 1914 Yrs 94 215-01-6176 Director Heual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 USA 1417 Autumn Leaf Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕽 No Specify: Specify: white Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John P. Roberts Henrietta Slowik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a /daughter 1417 Autumn Leaf Road; Towson, MD 21286 Eleanor C. Krajewski other t perrit. Pages 1 an Deportment of Heal Important: If Item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren
4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Dehage 3 ☐Removal from State Dulaney Valley Mem Gardens 🖯 8/5/08 Timonium, MD 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one came on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a Ö 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed Yes 2 No or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After or Attending Division 1 Natural 5 Pending investigation To the ruce.
within 24 hours after use...
To the Funeral Director: After 1 TYes 2 TNo 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YOUK 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

08-05682 Evan Nielson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 24921

		1- For State Registrar Certificate of Death	Reg.	No.	00 6476
Physicia		Decedent's Name (First, Middle,Last)	2. Date of Death	Day Year	3. Time of Death
ledical Exami		CANA C.11(1311/103E0 40:10110ED 10:1203E10	July 24, 200	8	1455 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De	ath	4c. County of Deat Montgomery	h
		7051 Carroll Avenue Takoma Park	la Data de Bieth		the lass (Ctale
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours Months Days Hours Months Days Hours Months Days Hours Months Days Hours Months Days Hours Months Days Hours Months Days Hours Months Days Hours Months Days Hours Months Days Hours Months Days Hours Months Days Hours Months Days Hours Months Days Months Days Months Days Months Months Days Months Mo	Min.	(MM/DD/YYYY) 9. Bi Forei	gn WASHINLTON
Director	1	577-38-4499 1 M 2 F 77 Yrs. World's Days 10015	10/25/	1930 0	ountry)
A .	Ţ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
w any	ı				1 Yes 2 No
Aaryland 28a-f show 1 at once.	ē	MD MONTGOMERY TAKOMA PARK	140-	. Citizen of What Cou	
Mary - 28a- ad at	Director	10e. Street and Number 10f. Zip Code	109		untry?
with the Maryland ns 23a or 28a-f sho oe notified at once		7-01		USA	
th wil	Funeral	11. Mantal Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		White, etc.	rican Indian, Black,
or iten	교	Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify:		Specify: W	11.75
rs after ural", o	à.	or Dates:	of work done	6b. Kind of Business	
72 hours a n "natura al Examir	ted	Elementary/Secondary (0-12) College (1-4 or 5+)			
hin 7 hin 7 he. than	흴	12 CARPENTER		CONSTRU	LTION
15-0036 filed within 72 hours afte Hygiene. d other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name	ame (First, Middle, Ma	iden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be (H CHRIS	TIANSEN	7
21 hould I of Mer is man	၉	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number			
nore, MD 2 ages 1 and 2 shount of Health and It. If item 27 is rother traumatic		MASAKO NIELSEN/DAULUTER 125 VISTA VIEW DO			
Fe, I and I Heal	-1	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	or Town, State
Pages ent of		4 Donation 5 Other Specify: ARDENT CREMATORY	8/04/2008	HANOVE	2 MARTINES
Baltimore, permit; Pages 1 at Department of Her Important: If ite injury or other tr	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility			
m galii		17532 CONJELLEY	DR. STEN	HANDWIZ,	92016 gm
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.	ac or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	ì	Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease			Death
		or condition resulting in death) Due to (or as a consequence of):			
	ᡖ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	틭	cause. Enter Underlying Cause (Disease or injury that initiated			
1 8 8 641	Examiner	events resulting in death) Last Due to (or as a consequence of):			
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876 inficat ng ph			egnancy	Month	Day Year
Box 687 death certific the attending	sician	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
Bo; e deatl the atl	Phys	1 Yes 2 No 9 Unknown g Unknown		1	
P.O. es that the igned by	by P				to the cause of death?
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ords, w requir	Bet		autops	y prior to	completion of cause of
Recc The lav	Completed		perform 1 Y Yes 2		
tal Rec rian: The certificate ector, page	Bec	25. Was case referred to medical 26. Place of Death (Chi	eck only one)		
Vit hysica this c	To E	1 Yes 2 No I impatient 2 Ervoupatient 3 DOA		Residence 6 🗹 Oth	ner: Scene
n of ding Ph	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?		ow injury occurred	
Sior Attend r death ector: by the	atic	1 Natural 5 Pending 1 Yes 2 No			
P. B. B. E. E.	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, St		Rural Route Number, City
Di To the Hospital within 24 hours a Vo the Funeral I					
To the Howithin 24 For the Function To the Fun	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one) 2 W Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred.	and due to the cause red at the time, date a	e(s) and manner as st ind place, and due to	ated. the cause(s)
To t	Med	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (A	
		O.C.M.E.	OCME	July 29, 2008	
1.7		I peoder M. (4 of The mo			
341		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltin	nore, MD 21201		
9	tate				
Regis		ALLEO O A THEO SHAMPSEL AND APPLICATIONS			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July **Physician** 2008 9:15 Malcolm Hugh Nevin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Presbyterian Home Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-12-1929 9. Birthplace (State or Foreign **Funeral** Min. 1 ☑ M 2 □ F Months Days Hours Country) 276-26-4744 78 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Baltimore MD Towson the 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code with U.S.A. 21204 Apt. 125 400 Georgia Ct., death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after on the fleath and Mental Hygiene. It Item 27 Is marked other than "natural", or item It Item 27 Is marked other than "natural", or item Iny or other traumatic event, the Medical Eventinary or other traumatic event, the Medical Eventina 1 XXYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Finance Executive Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patience Sybrant ဂ Pressley Howard Nevin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Georgia Court, Apt. 125, Towson, MD 21204 Lida Mae Nevin / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
any Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nother (Specify) Entonibment Mausoleum Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** 595 one yes-/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? 1 □ Yes 2 ②No Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗋 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 037016

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 0 4

2008

2. Registrar's Signature

243.0

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kenuk M. Gerins 6701 N. Chevles St., Syte 41=5 1/5/14han, no 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Department of Health and M Certificate of Death		iene2 ()	08	24923
ı	Physicia	an	1. Decedent's Name (First, Middle, Last) Ada E. Ohrmann	2. Date of Death	n Dav	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	July 31	2008 4c. County	v of Death	6:10 P.M.
ار	Examin	er	Glen Burnie Health and Rehab. Glen Burnie				le1 County
F	Funeral Director		5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Wonths Days Hours Min.	8. Date of Birth (Month, Day,			olace (State or Foreign ntry)
	σ		Usual Residence of Decedent	Oct. 19	, 1924		Mexico
	tarylar show	5	10a. State 10b. County 10c. City, Town or Location			11	0d. Inside City Limits 1 ☐ Yes 2 No
	r 28a-1	Director	Maryland Anne Arundel Pasadena 10e. Street and Number Pasadena	10	Og. Citizen of	What Coun	
	ath with	ralD	8102 Sprague Drive 21122			LS.A	
^	fter dea ritems iner m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Specific Research Country)	ecify Yes or No- Rican, etc.)		ce - Americ ck, White, e	
2-003p	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Evaniner must be notified at	þ	If Yes, Give 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates:		Specif	'y: V	White
7	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Pacifical Evanings must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of worki life. DO NOT use retired)	ing 1	16b. Kind of B	usiness/Ind	dustry
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and	be file tal Hy sd oth event	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name			ne)	
Š	2 should be f n and Mental Is marked o raumatic eve	ဥ	William Henry Bailey Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	Kather			Powell Code)
Ξ	and 2 steath an m 27 is her trat		Fred C. Ohrmann (Son) 8102 Sprague Drive Pas	,	Marylar		,
ore,	ges 1 at of He If Item		20a. Method of Disposition 1	Date 2	20c. Location	- City or To	wn, State
Saltimor	permit. Page Department Important: If any injury or once.		4 Donation 5 Other (Specify) Parkwood Cemetery 08/02 21. Signature of Fundal Service Licensee 22. Name and Address of Facility	2/08 E	Baltimo	re. M	Maryland
ď	Dep Imp any	5 9	McCully-Polyniak Fu 3204 Mountain Road	neral Ho Pasadena	ome, P.	A.	21122
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac a shock, or heart failure. List only one cause a each line.				Approximate Interval Between Onset and Death
1	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)				2 year
1	Examiner		ruyto (or asy consequence of):			1	+ Vipars
-	sit sit	iner	Sequentially list conditions, if any list in models cause. Enter Underlying Cause Obsease or injury				7
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ŏ X	certific iding p se as t		IF FEMALE: 23c. If yes, outcome of pregnancy		204 D	de et delle	
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ds,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	d by	Tarti. Other significant conditions contributing to death but not resulting in the underlying cause given in Parti.	1 □ Ye		3 ☐ Prob	
ecords,	aw req as beer 2 shou	Completed		24a. Was ar			psy findings available
<u> </u>	: The cate had page	Com		autopsy perform 1 □Yes 2	ned?	death?	mpletion of cause of
V II a	or Attending Physician; Thi after death. Director: After this certificate in by the funeral director, pag	Be	25. Was case referred to medical examiner? 1				
5	ding Phy n. After this funeral d	n: To	27. Mannar of Death 28a. Date of Injury 28b. Time of 28c. Injury at	me 5 Reside 28d. Describe ho			<u>v)</u>
VISION	tendin leath. tor: Af the fur	catio	2 Accident investigation M 1 Yes 2 No				
	after d after d Direct	Certification: T	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town	eet and Num. , State)	ber or Rura	I Route Number,
	ospita hours uneral		29a. Certifier (Check only (Check only a place) 29a. Certifier 1 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and place are consistent of the place and place.	and due to the ca	ause(s) and n	nanner as s	itated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate in completely filled in by the funeral director, page	Medical	29b. Signature and title bicertifier . 29c. License number		9d. Date signe		
	F ≥ F 8		FULLY Klock 020094	23	08/0	1/28	
	7		30. Name and address of person of o commented cause of death (horn 23a) (Type, Print)	A.	11	1 B	as hell .
(Sta	to.	31. Date filed (Month, Day, Year) 322. Registrar's Signature	Drive	+ Ulas	Di	11 AIP WI, 2106
	'Registr		AUG 0 4 2008 April				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar		State	of Marylar	•	artmen rtificate			and M		Rag. No	7 1 1		2492	
). (_w	Physici /Medio Examir	al	1. Decedent's Name (First, Mic Anna May Org 4a. Facility Name (If not institut 2301 Poplar D	an ion, give s	treet and nu	mber)			Town, or	Location o	of Death	2. Date of D Month July 3	Day 31, 20	008 County of	Death	3. Time of Dea	
·K	Funeral Director		5. Social Security Number 213-09-5294 Usual Residence of Decedent	6. Sex	M 2[XF	7. Age (In yrs. 92	/ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth	altim 16		ce (State or Fo MD	reign
	within 72 hours after death with the Manyland ene. 190. 1919	ector	10a. State 10b. Cour	T IMOI	RE	10c. <i>C</i> i	ty, Town or Lo		Code				10a Citiz	en of Wha		. Inside City Li 1 ☐ Yes 21x	
	23a or 3	Funeral Director	2301 POPLAR	DRIV	Ξ			101. Zip		1207			UNITE				
980	s 1 and 2 should be filed within 72 hours after death with the Marylan fellential and Mental Hygiene. A struct is or Items 23a or 28a-1 show other traumatic event, the Medical Exertions must be notified at	Ď	11. Marital Status 1 Never Married 2 N 3 Widowed 4 Divorce	arried	2. Was Dec Armed F 1 ☐ Yes If Yes, G Year or I	2 No		Was Deced If Yes, spec		spanic Ori n, Mexican Specify:	gin? (Spo i, Puerto	ecity Yes or N Rican, etc.)		4. Race - Black, Specify:	White, etc		
21215-0036	within 72 ho lene. then "natur the Medical	Completed	15. Decec (Specify only hig Elementary/Secondary (0-12 3RD		ation completed, College		16a. Dece (Give life. SELF	kind of wo	rk done d se retired	turing mos		ing		nd of Busin		stry	
g	2 should be filed and Mental Hygis Is marked other aumatic event, it	To Be C	17. Father's Name (First, Midd JOHN RILEY	le, Last)								(First, Midd	le, Maiden	Sumame)			
	and 2 sho eaith and I n 27 is mu		19a. Informant's Name/Relation JOSEPH ORGAN				19b. Mailii 2301	ng Address POPLA	(Street a	and Numbe	BAL.	I Route Num	MAR	Town, Sta YLAND	ate, Zip C 21	207	
a)	Pages 1 and of Hesen of Hesen of Hesen of Hesen of Hesen out. If Item		20a. Method of Disposition 1 X8urial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		emoval from	0	Place of Dispo cemetery, crei CRED HE	matory`or o	ther plac	SUS		Date / 2008		cation - Cit	•		
Balti	permit. Pages Department of the Important: If its any injury or of pages.		21 Signature of Funeral Servi	ce License	9							rles S Balti					
	nysician /Medical Examiner		23a. Part 1 Enter the disease shock, or heart fallers. Immediate Cause (Final disease or condition resulting in death)	or complication of the control of th	cations that e cause on Due to	caused the dea each line. Thur for as a consec Thur	th. Do not ent	ter the mod	le of dyin	g, such as	D L	or respiratory	arrest,		11	pproximate iterval Betwee Inset and Deat	n th
,760,	te be executed ysicien and te burial-transit	dicai Examiner	Sequentially list conditions, and leading to minimal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b c	Due to	(or as a consec	guence of):	rosi	9								
P.O. Box 6	The law requires that the death certifica site has been signed by the attending ph bage 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2:	1 Live	Itcome of pregn birth 2 Fets nant at time of c	al death 3	⊒Ectopic pr ⊒ Other (sp						3d. Date o		ay Year	r
rds, P	w requires thet been signed b should be deta		Part II. Other significant cond	litions con		nelli f		inderlying c	ause giv	en in Part I	•	_	tobacco u Yes 2			cause of death	
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Vital	ysician: is certific director,	o Be	25. Was case referred to med examiner? 1 ☐ Yes 2 📉 No		ospital:		3=D/O		Oth			h (Check onl)					
Division of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Per 2 Accident inve	stigation	28a. Date	Inpatient 2 of Injury oth, Day Year)	28b. Time o Injury		8c. Injun Worl	/ at		me 5 XRe 28d. Describ					
		Certification;		ld not be emined	28e. Plac build	e of Injury - At h ling, etc. (Speci	iome, farm, st fy)	reet, factor	y, office				(Street and own, State,		or Rural I	Route Number,	
	To the Hospitel or within 24 hours effe To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certification (Check only 2 Media	ying Phys al Examir	er: On the	e best of my knoossis of examination of examinations.	owledge, deat ation and/or in	h occurred ivestigation	at the tin , in my o	ne, date an pinion, dea	d place, th occuri	and due to the	e cause(s) e, date and	and mann place, and	er as stat due to ti	ed. ne cause(s)	
P		Me	29b. Signature and title of Gen	the	^. ´	An	0	290	C. Licenso	o number	50		29d. Dat	e signed (/ 21/2	Month, Da	ay, Year)	
5	4		30. Na and address of pers	_	RRES	M_D.	m 23a) (Туре,	Print)	LLV	vood	AU	E, BA	LTIM	one,	MD	212	24
	Sta Registi		31. Date filed (Month, Day, Ye	ar) 2008	100	Registrar's Sign	ature Son	ويجوه				•					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August 2, 2008 KENT HOWARD 6:38 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center 8. Date of Birth (Month, Day, Year) Be1 Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country)
1960 Florida 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**√** M 2□ F Hours Min 215-76-8591 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Eventine round by notified at 1 Yes XX No Director MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 S. Tollgate Road 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 Tyes 2 No White Completed by Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Chef Resturant Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Pelletier Germain Barbra A. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If item 27 is any Injury or other transconce Barbara Pelletier (mother) 410 S. Tollgate Road Bel Air, MD 21014 Date 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Termation 3 ☐ Removal from State Bayview Crematory 08/04/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licenses 610 West MacPhail Road, Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) ng physician and as the burial-transit Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ♠ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Vital 1 Yes 2 No 1 ☐Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) elletier, kent Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Division of completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

Dr, Mohammed Afzal

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idusta,

M80048433

BelAir,Md. 21014

500 UpperChesapeake Dr.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 940AM 200 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TIMORE TIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 25,1945 Birthplace (State or Foreign Country) 5. Social Security Number UNI 6. Sex 7. Age (In vrs. last hirthday **Funeral** Months Days Hours Min. 1 € M 2 □ F 63 Iowa Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Marshalltown Iowa Marshall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 50158 United States 2425 Jessup Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2**X** No Specify: White Specify: 3 Widowed 4 Divorced 'natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ul Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking orrould be filed and Mental Hygis m 27 is marked other the straumatic events 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked of any Injury or other traumatic ev Mary Joan Johnson ဂ Howard Wayne Rice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2425 Jessup Avenue, Marshalltown, Iowa 50158 Anna Rice, Wife Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1X Burial 2 Cremation 3 Removal from State Laurel Hill Cemetery 08/08/2008 Des Moines, Iowa 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell Family Funeral Home ef Funer | Se M01113 1209 Iowa Avenue W, Marshalltown, IA 50158 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final . Physician therosderos, disease or condition resulting in death) /Medical Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and the burial-tra Due to (or as a consequence of) P.O. Box 68760, physician use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ģ in the past 12 months? 5 Other (specify) signed by the a I be detached for 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2. No 2 🗆 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide LX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

Registrar's Signature

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TILEM#205, perfet, \$82,8/8/05,W5

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Louis H. Rettberg 2008 4:00am /Medical August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Misty Ridge Assisted Living Sykesville Carro11 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 212-32-4749 1**7**2 M 2 □ F 74 Yrs. Director July 23 1934 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any inJury or other traumatic event, the Medical Examiner must be notitied at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Carrol1 Sykesville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2117 Carroll Dale Road 21784 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married A Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) insurance insurance claims director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis H. Rettberg Jr. Margaret Roeder ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gary A. Rettberg (son) 703 Benjamin Rd., Bel Air, MD 21014 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Wesley Freedom Cemetery 8-7-08 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee + Parge Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Mou /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy ate has been signed by the atte page 2 should be detached for Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospital: 1 Yes 2 No ည 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred FACILITY 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. Box 386 ELDERSKURG MP. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent Name (First, Middle, Last, 2. Date of Death Physician /Medical or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner msville 9. Birthplace (State Country) If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Ye last birthday) (State or Foreign Age (In yrs **Funeral** Months 1 M 2□F 0 Days Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at BaltiMore 1 Yes 2 No Director 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number ō 23a death Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Yes 2 No f Yes, Give 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 2 3 ☐ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 18 Mother's Name (First Middle Maiden Surname 17. Father's Name (First, Middle, Last Be Pages 1 and 2 should be f nent of Health and Mental I ပ ۵ nant's Name/Relationship (Type Frint) 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) of Health and Item 27 Is r 41115 slumbia, Ma Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 'Department of HIMportant: If ite any injury or of Balto, Ma 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MOUNT 21. Signature of Funeral Service Lice 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed transi and the burial-Box 68760, physician Physician/Medical as attending for use a IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9□Unknown 9 ☐ Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, λq 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed The law r 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page certificate 1∐ Yes 2 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 1 🔲 Inpatient No No 2 ER/Outpatient ٩ 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation Hospital or Attending 1X Natural (Month, Day Year) Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 moting Moream 2008

State

Registrar

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SMITH **Physician** W. 01)1 31 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai battimore N Hospital 7. Age (In vrs. last birthday) Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 □ F Months Days Hours Country) Director irainia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director More 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 0 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) HOFFMAN Elementary/Secondary (0-12) College (1-4or 5+) mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Smith Edward ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of HImportant: If iter
any injury or oth 1 Burial 2 Cremation 3 Removal from State 49,8,2008 OWINGS MILLS, MD, Forest 4 ☐ Donation / ☐ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility 70 23a. Part 1 Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, when trailure. List only one cause the each line.

Immediate Jayre (Final disease or or didition resulting in death)

a. Report of the mode of dying, such as cardiac or respiratory arrest, shoot, when the mode of dying, such as cardiac or respiratory arrest, shoot, when the mode of dying, such as cardiac or respiratory arrest, shoot, when the mode of dying, such as cardiac or respiratory arrest, shoot, when the mode of dying, such as cardiac or respiratory arrest, shoot, when the mode of dying, such as cardiac or respiratory arrest, shoot, when the mode of dying, such as cardiac or respiratory arrest, shoot, when the mode of dying, such as cardiac or respiratory arrest, shoot, when the mode of dying, such as cardiac or respiratory arrest, shoot, when the mode of dying, such as cardiac or respiratory arrest, shoot, when the mode of dying, such as cardiac or respiratory arrest, and the mode of dying, such as cardiac or respiratory arrest, and the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the mode of dying are discovered by the di march Funeral Home. Eucto, rud. 2122 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner 5 Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit P.O. Box 68760, Physician/Medical ed by the attending p detached for use as IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9□Unknown To the Hospital or Attending Physician: The law requires that th within 24 hours affer death.

To the Funeral Director; After this certificate has been signed by a completely filled in by the funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 SC 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performeg 2 1 N 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ို 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 U ural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖵 🚾 rtifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type 30. Name and address of person who completed, 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Smith

Patrent known

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician July 28 2008 Svehla 05:17 P ^M Rita Lorraine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Baltimore Towson 8. Date of Birth Month, Day, Yea Aug. 24, 5. Social Securify Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 4^{Year)}1921 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 21 F Louisiana 438-14-8426 86 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Merflet Hygiene. Important: If time 27 is ansked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TxNo Marion Director FL Summerfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 9611 S.E. 170 Place 34491 Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛣 No Specify. 2 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theriot Emma Tassin Andrew Henry ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6727 South River Dr., Baltimore, MD 21220 Lorraine Upton (Daughter) Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Pages . Baltimore Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/31/08 4 Donation 5 Other (Specify) @ Loudon Park Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licen 3620 Wilkens Ave., Baltimore, MD 21229 olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final **Physician** disease or condition resulting in death) pheuman /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the conditions of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No for 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the 9☐Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 211 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 201 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

the death certificate be executed Division or Vital Records, P.O. Box 68760, Physiclan:

Medical

State Registrar 29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Towson MD 21204

29b. Signature and title of certifier

Cosneli

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician 933 M Smith 2008 Evelvn Μ. 29 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Agnes Hospital Saint N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Pay, Year) May 29, 1914 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Mary Tand 1 □ M 2 T F May 215-05-1252 94 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Even it are must be confined at 1 X Yes 2 □ No Director Maryland | N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21229 1023 Maiden Choice Ln. Apt 4 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 ▼ No White ≥ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Mental Industrian or other traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roikes Kuh1 Mary George ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 427 Upper Georges Valley Rd., Spring Mills, PA 16875 Colleen Ott (Niece) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Baltimore Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) loudon Park 8/5/08 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Liberar e 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 5 hours Physician Due to (or as a consequence of): /Medical Examiner rengl ta: INTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed hrombosis and Due to (or as a consequence of) burial-P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 XNo 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 X No 3 Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 X certificate 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

completely

Evelyn

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certific

30. Name and address of person white impleted cause of death (Item 23a) (Type, Print)

4

99920910U

32. Registrar's Signature

900

29c. License number

AS24385284106

Caton Ave

29d. Date signed (Month, Day, Year)

Baltimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - State Registrar	State of Mar		artment of F		Mental Hy	giene Reg. No. 20	08 249	3 2
	Physici		1. Decedent's Name (First, Middle, Last) Henry Charles	Roe Short				2. Date of De		3. Time of Deat	th AMM
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Deat		4c. County of	of Death	7111
	Funeral Director		210-03-32/0	7.Age (KM 2□F	In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		915	9. Birthplace (State or For Country) Maryland	reign
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	th with the	al Director	10e. Street and Number 1014 Hanson Roa	ad		10f. Zip Code 21085			10g. Citizen of W	/hat Country?	
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	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Tyg. Bette C. Short ,		r 1014	Hanson	Road	Joppa,	Maryla	and 21085	
	Page nent c ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		d Cemet	ery; 8/4		Baltimo	City or Town, State ore, Maryla	
Ba	permit. Departr Imports any Inje		21. Signature of Funaral Service License	2.11	F	2. Name and Addre	son Fur			204 50 York Roa	
	Physician /Medical Examiner		23a. Part 1. Enfer the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line. Due to (or as a c	CATOL consequence of):	7 FAI	LAC	c or respiratory a	rrest,	Approximate Interval Betweer Onset and Death	h
50,	ricate be executed physician and sthe burial-transit	Sequentially list conditions, if any, leading to turniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of). Leading the conditions, if the conditions is a consequence of the cause. Enter Underlying that initiated events resulting in death) Last Dus to (or as a consequence of):									
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Hec	ine la ate has page 2	Completed						24a. Was autor perfo 1 □ Yes	osy p rmed? d	Vere autopsy findings avail prior to completion of cause leath? ☐ Yes 2 ☐ No	able of
r Vital ∷	rnysician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1	2 ER/Outpatie	nt 3 □ DOA Oth	or.	ath (Check only only only only only only only only	one) dence 6 □Othe	er (Specify)	
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DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	(Specify)			City or To	vn, State)	er or Rural Route Number,	
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	with To 1	W	29b. Signature and title of certifier	TENDI	NE PHYSIC	29c. Licens		-38 0	A	(Month, Day, Year)	
l	0		30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (Type,	Bellon	n Ave	Suite	120 70	108 ourson MD212	roy

State Registrar

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	Funeral Director		5. Social Security Number 440-28-5243 Usual Residence of Decedent	7. Age (In yrs. I	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	orth (Pear) (29 , 1927)	9. Birthpla Count Kan	ace (State or Foreign ry) Sas
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	ctor	10a. State 10b. County Maryland Baltimor		, Town or Loc	sville				10	d. Inside City Limits 1 ☐ Yes 2XXNo
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		ry?
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36	be filed within 72 hours after death with the Marylan Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Evancher must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.3 Armed Forces? 1		Vas Decedent of I fYes, specify Cub □Yes 2X□No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecity Yes or N o Rican, etc.)	o- 14. Had Bla Specif	ce - America ck, White, et y:	
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	Examiner	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):					-	
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O	ding th. Afte fune	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	Wo	rk? ⊒Yes 2.⊟No				
Division	al or Attending s after death. I Director: Afte d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stro	eet, factory, office			(Street and Num own, State)	ber or Rura	Route Number,
	To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C		sician: To the best of my kno ner: On the basis of examina and manner stated.							
	To the I within 2 To the I complet	×	29b. Signature and title of certifier	· M	7		se number		29d. Date sign		
	18		30. Name and address of person who co	ompleted cause of death (Item	1 23a) (Type,		0-1	16+	July		, 2008
	Q		Abdallah Karroui 31. Date filed (Month, Day, Year)	32. S egistrar's Signa		0	, Ronda	115 low.	N, MD	211.	55
-	Sta Registi			ns Sz. Jegistrai s Signa	I A	CARL!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ORI 12:35 PM SCHENNING TUL 700B 29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex **Funeral** 1□ M 2□√F Months Days 214-76-9055 48 MI). Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f showing Medical Even for must be notified at 1 Tyles 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 21224 807 FAGLEY ST. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes X☐ No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LEGAL SECRETARY LAWYER is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fil of Health and Mental F f item 27 is marked otl Be JOHN M. SCHENNING VIRGINIA REBBEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIRGINIA SCHENNING 3802 FAIT AVE., BALTIMORE, MARYLAND 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Pages 1 ö permit. Pages Department of Important: If it any Injury or or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART OF JESUS 8/2/2008 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service License 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 100 Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseas shock, or heart failure. trations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line Immediate Cause (Fixal-**Physician** HYPERCARBIC RESPIRATORY FAILURE HOURS disease or condition resulting in death) /Medical Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEAGE 3 YEARS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed and burial-tran Due to (or as a consequence of) physician the burial Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. 1 □Yes 2 □ No. the 9 Unknown signed by t Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28b. Time of 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

RES-000

4940 BASTERN ANONNE, BALTIMORE ND 21224

JULY 29, 2008

Registrar

Year)

KAVITA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MP.

Registrar's Signature

ORIGINAL

		For State Registrar	Plea	se Type oi State			d / Depa		Health and	-		e	2 21.0	3
Physicia /Medica		1. Decedent's Name	,	e, Last) ABETH ST	OCK					2. Date of De	ath	^{ay} 2008 Year	3. Time of Death	
Examine	er		E GENES	IS NURSI	NG C	CENTER		DUNDALK	or Location of Death]	c. County of Death	Ε	
Funeral Director		5. Social Security N 216-01-8 Usual Residence of	3096	6. Sex 1 ☐ M 2 ☐ F	7. Ag	95	a <i>st birthd</i> ay) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da JUNE 1	orth iv Year 6, I	913 MAR	hplace (State or Fore YLAND	ign
Maryland a-f show	tor	10a. State	10b. County	N/A		10c. City	, Town or Lo		IMORE				10d. Inside City Limi	
th with the 23a or 28 ust be not	ral Director	10e. Street and Nur 317 S. E		STREET		,		10f. Zip Code 21224			10g. C	itizen of What Co	untry?	
urs a	by Funeral	11. Marital Status 1 □ Never Marri 3 █ Widowed	_	12. Was De Armed I 1Yes If Yes, (Year or	Forces? 24 Give			Was Decedent of H fYes, specify Cub I⊡Yes 2 No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.))-	14. Race - Ame Black, White Specify: W		
within 72 hours ene. than "natural" e Medical Ex	Be Completed	(Spec		's Education t grade completed College	·	5+)	(Give	DO NOT use retire	during most of wor	king		Kind of Business/I	•	
ld be filed v fental Hygie ked other ic event, u	To Be Co	17. Father's Name		Last) NRY RUTH			<u> </u>		18. Mother's Nan		L		d Dam	
and 2 should be eaith and Mental m 27 is marked oner traumatic even		19a. Informant's Na		nip <i>(Type. Print)</i> GER- DAU	GHTE	ER		,	and Number or Ru Y STREET		. ,		,	
pcrmit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other traumatic event, the Medical Other.		4 □ Donation 21. Signature of Fu 23a. Part 1. Enther shock, or rea Immediate Cause disease or conditio	Cremation 5 Other (S) uneral Service the disease, or the failure. List (Final	Licensee		SACE	RED HE 22 6	2. Name and Address 224 EAST er the mode of dyi	ESUS8/4/2 ess of Facility C ERN AVENU	CHARLES JE BALTI c or respiratory a	BAI S. 2 MORI	ZEILER & E, MD 21	MARYLAND SON	
be icia		Sequentially list co- if any, leading to im- cause. Enter Unde Cause (Jacob of that initiated events resulting in death) I	nditions, mediate ritying it jury Last	b. Due to	SS o (or as	a conseque a conseque a conseque	ence of):	AL	HYPI	ERTI	En	(SION	30 YEA	7
Physician: The law requires that the death certificate risk certificate has been signed by the attending physical director, page 2 should be detached for use as the I	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 2 9 ☐ Unknown	morths? ⊒No		e birth gnant a	of pregnar 2 □ Fetal It time of de	death 3	Ectopic pregnand Other (specify)	су			23d. Date of deli Month	very Day Year	
n requires that the d been signed by the should be detached	2	Part II. Other signif	ficant condition	ns contributing to	death b	ut not resul	Iting in the ur	nderlying cause giv	ven in Part I.	23e. Did 1		, /	the cause of death?	
ding Phystcian: The law n h. After this certificate has be funeral director, page 2 sh	Completed	05 M								24a. Was auto perfo 1 □ Yes	an psy ormed? 2 N	prior to death?	topsy findings availab completion of cause of 2 No	ble of
ysicia is cert directo	o Re	25. Was case referrexaminer?	No	Hospital:] Inpatie	ent 2 □ E	ER/Outpatien	it 3 DOA Oth	26. Place of Dea			6 ☐ Other (Spec		
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pital or Att		3 Suicide 4 Homicide 29a. Certifier	6 Could r	ned 286. Plac buil	ding, et	c. (Specify,)	eet, factory, office		City or To	wn, Stat	te)	ral Route Number,	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	Medical	(Check only one) 29b. Signature and	2 Medical l	Examiner: On the	basis o	f examinati	viedge, deatr ion and/or in	vestigation, in my	me, date and place opinion, death occu se number	e, and due to the irred at the time,	date ar	s) and manner as nd place, and due ate signed (Monti	to the cause(s)	_
7		30. Nama and addr	Pes of person	who completed da	Se of d	- M	(23p) (170),	Print) CU16	14160) -	Hu	GULTE C	2,200	5
State		31. Date filed (Mon	th Pay, Year	ALT IN	Registr	ar's Signar	MA	PG C	ant	(22	5	(जन्म		

Flease Type of Print in Black Indelible ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 24936 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day ^y 2008^{Year} Teresa Lynn Tipton /Medical August 3, 1:58 A.M ^{4a}. Facility Namp (*If not institution, give street and number*) GIIChrist Center for Hospice Care Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Social Security Number | It Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 9, 1963 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2XXF Director 220-88-6239 Yrs. 45 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 28a-f shov 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the "sedical Examinar must be notified at 10d. Inside City Limits Directo Maryland Baltimore Butler 1 ☐ Yes 2/OXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2401 Stringtown Road, P.O. Box 84 United States Funeral 21023 America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married δ 1∐Yes 2XXXVo 3 ☐ Widowed 4XX Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Seamstress Clothing Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Tipton မ Charlotte Ruth Bookhultz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Lee Sherman (Companion) Stringtown Road, P.O. Box 84, Butler, MD 21023 ltimore, 2401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 7, 20c. Location - City or Town, State 1 ☐ Burial 2 ★ remation 3 ☐ Removal from State 4 ☐ Donation (5 ☐ Other (Specify) Metro Crematory 2008 Catonsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 21a Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Impordiate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immunicate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Date to (or as a concequance of). To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760% Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 🔲 Ectopic pregnancy P.O. I Month 5 ☐ Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autops, performed: 2 No 1 ☐ Yes 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud/Balto Favlores MD, 555 lowsontown 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 M 2□F Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Numbe "natural", or items 23a edical Examiner must b 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2XNo Baltimore, Maryland 21215-0036 Black þ 3 Widowed 4 □ Divorced Completed of Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. De NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) y/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last, Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemptery, crematory or other place, 20a. Method of Disposition permit. Pages Department of H Important: If ite any injury or of Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Greene Funeral Services 21. Signature of Funeral Se 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician perten SI resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 🗌 No 2 Accident within 24 hours after death

To the Funeral Director: completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛛 💢 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) marrew D27716 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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2. Registrar's Signature

Forderick pd Baltimor MD:21229

		1- For Amend 30 per verb	of Maryland / Dal G882, 8/4	Department of Holes to the Control of L	ealth and Me Death	ntal Hygien Reg. N	°2008	24938
. Physi /Med		Decedent's Name (First, Middle, Last)	1	1		. Date of Death	ay Year O ZOB	3. Time of Death
Exam		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Balty	rove, Mi	cryland 4	c. County of Death	e City
Funera Directo		5. Social Security Number 6. Sex 1212-26-8659 1 M 2 1	7. Age (In yrs. last birt	Yrs. If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Year Nov 6, 19	r) Countr	ce (State or F abl ign y) ersey
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ING ZIZI3-UU30 be filed within 72 hours after death with the Marylar ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	hy Fineral		ecedent Ever in U.S. Forces? es 2 🔼 No Give	13. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X No	spanic Origin? (Specin, Mexican, Puerto Ric Specify:	fy Yes or No- can, etc.)	14. Race - Americar Black, White, et Specify: Whi	tc.
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2 5 # 2 T		Vernay Wescoat	(Wife)	894 Gordon D	rive, Gler	Burnie,	Maryland	21061
Pa Pa ant:		20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	om State 20b. Place of Cemeter Meado	f Disposition (Name of ry, crematory or other place Wridge Mem P	k 8/2/20		kridge, Ma	•
Denmit. Departi	ouce.	21. Signature of Furleral Service Licensee Ke	vin E Ecker	McCully-Po 237 E. Pat	s of Facility 1yniak Fur absco Ave	neral Home	e, P.A.	1225-1856
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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	legipo	29a. Certifier (Check only one) 2 Medical Examiner: On the and r	the best of my knowledge ne basis of examination an nanner stated.	nd/or investigation, in my op	pinion, death occurred	d due to the cause d at the time, date a	(s) and manner as sta and place, and due to	ited. the cause(s)
To t To t	NA.	29b. Signature and title of certifier	Deluica N	1) 29c. License	3001	29d. E	Date signed (Month, D	1 2009
6		30. Name and address of person who completed of			01007	17.14	<i>y</i>	
Regi	State stra	ALICA / 2008 /65	2 Pogistrar's Cignoture	Baltimore, MI David	21225			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2008 Month Physician WH 101 1 UZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE IMORE CIT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. **Funeral** 1 M 2 □ F Months Days Hours Min. Director Usual Residence of Decedent 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other than that mark in the 25 mins be notified at any Injury or other traumatic event, "It is decided to the property of the prope 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director 100 Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 __Yes _ 2 __No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Scondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surnai 17 Father's Name (First Middle Last) Be ൧ formant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 🤌 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 □ Donation 21. Signature 23a. Part 1. Er e, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Suse (Final disease or condition resulting in death) Physician ACUTE MYOCARDIAL INFARC-/Medical Due to (or as a consequence of): Examiner ATHEFOSCLEPOTIC CARDIOVASCUL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ MELL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy certificate perform 2 No Division of Vital 1 ☐ Yes director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 은 this 28a. Date of Injury (Month, Day, Year) After th funeral Certification: 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death **To the Funeral Director:** сотріете jilled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar KERITE

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

5601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOX

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2008

M.D.

32 Registrar's Signature

Registrar

State

31. Date filed (Month, Day, Year)

AUG 0

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MERCY MEDICAL

EUTER 301 ST PAUL STREET, MARYLAND 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Vaughn W. Zorn 2008 3:03a /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll Weschiller 1 Year | If Under 24 Hrs. Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 140-38-9968 62 Director 1946 July 10 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carrol1 Finksburg 1 ☐ Yes 2 ☑ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō pe 2119 Paddock Lane 21048 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify Specify: white Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) automotive auto parts salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ot J. Donald Zorn Margaret Whittington ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Queen Zorn (spouse) item 27 i 2119 Paddock Ln., Finksburg, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial 8-5-08 |Marriottsville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ Haige Haight & P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) P1051-12 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed after death. Division or Vital Records, P.O. Box 68760, & Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ∏Yes 2 ∏No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours at To the Funeral D 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

32. Registrar's Signature

	, - , -	Please Type or Print in Black In State of Maryland / Dep		=	_
			rtificate of Death	Re	g. No. 2008 24942
Physic /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> <u>Lee</u> Edward Alderdic	ce	2. Date of Death Month July 17	Day Year
Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	7	492 Sara Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Annapolis If Under 1 Year If Under 24 Hrs.	9 Date of Birth	Anne Arundel
Funeral Director		463-34-2224 1 M 2 F 79 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, 6/20/192	Year) 9. Birthplace (State or Foreign Country) 29 Texas
ryland how		10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
r 28a-f show	Director	Maryland Anne Arundel Annapolis	3		1 □Yes 2 No
Vith th	Ö	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
eath w	eral	492 Sara Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21401	enifu Von or No	USA 14. Race - American Indian,
72 hours after death with the Maryland natural", or items 23a or 28a-f show Most Examinar rust by myllfind at	by Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: White
"natural";	ted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	16	6b. Kind of Business/Industry
ithin 7	햩	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)	I .	3 77 OTT
Dermit. Pages 1 and 2 should be flied within 72 hours aft Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event, Item Medical Examinance.	S	5+ Self-	employed	e (First, Middle, Ma	Real Estate&Financial
d be f ental I ced of	To Be Completed	Jennings Bryan Alderdice		e (First, Middle, Ma Lee Smith	
Should nd Me mark matt	ř		ng Address (Street and Number or Rur		
alth a	3		ara Dr. Annapolis		
es 1 a of He of He fitem		20a. Method of Disposition 20b. Place of Dispo			Oc. Location - City or Town, State
Page ment ant: I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Cre		/2008 E	Edgewater, Maryland
permit. Pages 1 and 2 should be flied within 72 ho Department of Health and Mental Hygiene Important: If Item 27 is marked other than "naturany injury or other traumatic event, Item Medical Once.		21. Signature: Funeral Service Licenses	Name and Address of FacilityGeo.	rge P. Ka nd Rd. Ed	las Funeral Home gewater,Md.21401
		23a. Part 1. Inter the disease or complication, that caused the death. Do not entshock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition regulfities in chooting)	CANCER		Onset and Death 22 mcs
/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):			
eath certificate be executed attending physician and for use as the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):	-		
cate b	dical	d			
ding p	/Mec	IF FEMALE: 23c If we outcome of programmy			
ne death of the atten- hed for us	Physician/Medic		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ires that the de signed by the a be detached t		Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
quires n sign	d by			1 □ Yes	2 No 3 Probably 4 Unknown
aw requir is been s 2 should	Completed			24a. Was an	24b. Were autopsy findings available
The I	E O			autopsy performe 1 □ Yes 2 J	prior to completion of cause of death?
Physician: The law this certificate has b al director, page 2 s	Be C	25. Was case referred to medical examiner?	26. Place of Death	1 □ Yes 2, n (Check only one)	XNo 1 ☐ Yes 2 ☐ No
hysre this ce al dire	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other; 4 Nursing Ho	me 5.2 Residen	ce 6 ☐ Other (Specify)
ktending Phy death. ctor: After thi y the funeral c	Certification;	27. Manner of Death 1 (Natural 5 Pending investigation 2 Accident Could be the control of the country Could be the country Could be the country Could be the country Coun	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how	injury occurred
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, strubullding, etc. (Specify)		City or Town,	
he Hosp in 24 hou he Funei pletely fil	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, deatled the basis of examination and/or in and manner stated.	n occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cau red at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
To the within 2 To the complete	Σ	29b. Signature and title of certifier	29c. License number	290	i. Date signed (Month, Day, Year)
		thy / Whin ha	DO-8118		JULY 17, 2008
156		30. Name and address of person who completed cause of death (Item 23a) (Type, STANLY WATKINS 900 BES)		MAPULIS	mo 21401
Sta Registr		31. Date filed (Month, Day, Year) JUL 18 2008 32 Registrar's Signature	40		
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		ORIG	INAL		

			For	State of Ma	#30 perlyk. iryland / Der			Mental Hy	giene [°]	2000	2434
			State Registrar		Ce	ertificate of	Death		Reg. No.		
	Physicia	an	Decedent's Name (First, Middle)					2. Date of D	Day	Year	3. Time of Death
	/Medic	al	Arthur E. Ais			4b Oit True	ar Langtion of Dooth	July 2		onty of Death	7:51 PM ^M
1	Examin	er	4a. Facility Name (If not institution Anne Arunde1	,	0.14	Annapo1	or Location of Death	1		e Arun	
H		#C	5. Social Security Number		e (In yrs. last birthda			8. Date of Bi	irth	9. Birth	place (State or Foreign
	Funeral Director		216-22-3397	1 M 2 □ F	81 Yrs.	Months Days	Hours Min.	Mar 1			intry) Vland
	p		Usual Residence of Decedent					11101		11101	
	show d at	_	10a. State 10b. County MD Anne	A 1 - 1	10c. City, Town or						10d. Inside City Limits 1 ☐ Yes 2√2 No
	ne Ma 8a-f s	cto		Arundel	J	essup			40- 00-	-634/61-0	
	vith th	Funeral Director	10e. Street and Number	D 1		10f. Zip Code	00707			of What Cou	intry?
	s 23e	eral	7815 Sellner	12. Was Decedent 8	Verin U.S. 1	3 Was Decedent of	20794			SA Race - Ameri	ican Indian,
	item item iner r	ij.	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed Forces?	lo	Was Decedent of If Yes, specify Cul		o Rican, etc.)		Black, White	, etc.
Š	urs af	by	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	45-46	1 ☐ Yes 2 🔀 No	Specify:		Sp	ecify: whi	te
Ž	2 hou	Completed	15. Deceden (Specify only higher	t's Education	16a. Dec	cedent's Usual Occu ve kind of work done	ipation	kina	16b. Kind	of Business/l	ndustry
7	e. an "r Med	nple	Elementary/Secondary (0-12)	College (1-4or 5	`life	DO NOT use retire	ed)	nang			
V	ed wi ygien ker th t, the	ဦ	12	0	ca	rpet clea		/F:		aurant	s
2	be fill tal H d oth even	Be	17. Father's Name (First, Middle,				18. Mother's Nan			rname)	
2	2 should be filed within 72 hours after death with the Maryland end Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	မ	George Roy Ai		10h Ma	uiling Address (Stree	Annie Ma			Turn State 7	in Cada)
2	12 sk thand 7 is n traun		19a. Informant's Name/Relations Judith Aist-Dv			Lake Shor				21122	p code)
ָר ע	1 and Healt em 2	l g	20a. Method of Disposition		20b. Place of Dis	sposition (Name of	- ;	Date		ion - City or 1	Γown, State
Dalillion	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 4 🖾 Donation 5 ☐ Other (S		cemetery, c	rematory or other pl	ace)				
	nit. F artme ortan Injur	- 4	21. Signature of Funeral Service	Licensee 1		22. Name and Addi					
Ď	permi Depar Impor any Ir		Ronald	S. Wade Dir	ector	State Anam Baltimore	tomy Board	d 655 W	. Balt	imore	Street
۲			23a. Part1 Enter the disease, or shock or heart failure. List	complications that caused	the death. Do not e	enter the mode of dy	ing, such as cardia	or respiratory	arrest,		Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	Se 1	icie du	ce to k	Clebsrell	a in	tecto	n	Onset and Death
)	/Medical		resulting in death)	Due to (or	a consequence of):						
	Examiner		Sequentially list conditions.	b							
-	Si Si	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
	ecute and -trans	xam	that initiated events resulting in death) Last	C	a consequence of):						
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700	icate phys s the			d							
Z C C	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transition.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					230	. Date of deli	very
Ď	death satte	iciaı	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at		3 □Ectopic pregnan 5 □ Other <i>(sp</i> ec <i>ify)</i>	icy			Month	Day Year
Ş	t the	hys	9 ☐ Unknown	9□ Unknown							-
Ď.	ss tha		Part II. Other significant condition	_	ut not resulting in the	e underlying cause g	iven in Part I.				the cause of death?
colos,	equire en siç ould b	pa	- Emply.	sema				10	Yes 2 l	No 3∏Pro	obably 4,⊠ŅJnknown
รู	law nas be	Completed by	/ /					24a. Wa	s an 2	prior to o	topsy findings available completion of cause of
_	The ate h	E C						per 1∐ Yes	formed?	death? 1 ☐ Yes	2 No
Z .	Physician: r this certifica ral director, i	Be (25. Was case referred to medica examiner?	44 44 4			26. Place of Dea	ath (Check only	one)		
5	shysi this c	은	1 Yes 2 No	Hospital: 1 Nnpatie		HEIR 3 DOA		Home 5□Re			zify)
	ting F. After funer	ion:	27. Manner of Death 1 Matural 5 □ Pendir	28a. Date of Inju (Month, Da		y W	uryat ork? ⊒Yes 2⊒No	280. Describe	e how injury a	ccurred	
2	death death ctor: y the	icat	2 Accident investi 3 Suicide 6 Could	not be 28e Place of ini	ury - At home, farm,			28f. Location	(Street and N	lumber or Ru	ıral Route Number,
2	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	4 ☐ Homicide determ	building, et	c. (Specify)	•			own, State)		
	hours hours meral y fillec			ng Physiclan: To the best							
	n 24 I n 24 I he Fu pletely	edical	(Check only 2 Medical one)	Examiner: On the basis of and manner st		r investigation, in my	y opinion, death occ	urred at the tim	e, date and pl	ace, and due	to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifie	1 /1			nse number				h, Day, Year)
			alail	elinests			57078		04	- 24-	2006

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

an Anne Arundel Medical Center Annapolis, MD
32. Registrar's Signature Jacqueline Susan Ryan
31. Date filed (Month, Day, Year) 32.

			for State Registrar	State of Marylan		artment of F rtificate of I			ene g. No. 200	8 24944
	Physici /Medic		Decedent's Name (First, Middle, Las Robyn Lynn BUTLEF	,				2. Date of Death Month July 22.	Day Year 2008	3. Time of Death
	Examir		4a. Facility Name (If not institution, given 11309 Greenberry 5. Social Security Number 6. Security Number 6. Security Number 6. Security Number 1. Security Number	Road		Hager	r Location of Death		4c. County of De	gton
	Funeral Director			ex	(ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 15		irthplace (State or Foreign Country) aryland
Daillingre, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Machal Experiment must be natified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Washing 10e. Street and Number 11309 Greenberry 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grace) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Clyde Richard Bar 19a. Informant's Name/Relationship (T. Robert H. Butler, 20a. Method of Disposition 1 Maurial 2 Cremation 3 14 4 Donation 5 Other (Specify, 21. Signature of Funeral Service License)	Road 12. Was Decedent Ever in U.S. Armed Forces? 1	16a. Deced (Give I) Ife. D Food s 19b. Mailin. 11300 lace of Disposemetery, crem Dadford	Vas Decedent of H Yes, specify Cube Yes 2 No Van Occup On NOT use retired Service w	ispanic Origin? (Sp. In, Mexican, Puerto Specify: atlon during most of work Orker 18. Mother's Nam Linda V and Number or Rur rry Road e) 7/25/ Cemètery	ecify Yes or No-Rican, etc.) ing Pe (First, Middle, Mairginia Ral Route Number, Called August 1988	g. Citizen of What C USA 14. Race - An Black, Wh Specify: 6b. Kind of Busines: ublic sch iden Surname) idge City or Town, State, OWD, Md. k. Location - City of	10d. Inside City Limits 1 □ Yes 2¶ No Country? Decican Indian, ite, etc. White s/Industry 2ip Code) 21740 rTown, State m, Maryland
<i>/</i> //	ysician and prize which we have the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or composhock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if my least ingrease or injury that initiated events resulting in death) Last	aDue ti (i r as a consequ	Do not entered sence of):	er the mode of dyin			town, Md.	Approximate Interval Between Onset and Death
The law requires that the death certific	by the attending ached for use as	Physician/Mec	in the past 12 months? 1 ☐ Yes 2 🖾 No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🗆 eath 5 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	Dlivery Day Year
requires th	s been signed should be det	à	Part II. Other significant conditions co.	ntributing to death but not resul	ting in the und	derlying cause give	n in Part I.			o the cause of death?
ian: The law	tificate has tor, page 2	e Completed	25. Was case referred to medical				26. Place of Death	24a. Was an autopsy performe 1 Tyes 2 Check only one)	prior to death?	utopsy findings available completion of cause of s 2 □ No
lor Attending Physician:	th is	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 6 Could not be determined	dospital: 1 ☐ Inpatient 2 ☐ E 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At hon building, etc. (Specify)	28b. Time of Injury	28c. Injury Work' M 1 □ Y	r: 4 □ Nursing Ho rat ? res 2 □ No	me 5 Residence 28d. Describe how	et and Number or R	ural Route Number,
ne Hospital	e Funeral	ledical Co	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	rledge, death on and/or inve	occurred at the timestigation, in my op	ne, date and place, pinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as	is stated. e to the cause(s)
Toth	To th comp	2	29b. Signature and title of certifier	n		29c. License		29d	Date signed (Mon	
SH-	-8			mpleted cause of death (Item 2	23a) (Type, P	rint) 5 m, ths	2471 burg	ms		
	Stat Registra	ır	31. Date filed (Month, Day, Year) JUL 2 3 20	32. Registrar's Signatu	ire	afe				

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifi

29b. Signature and title of certifier - IMD m 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Donna M. Vincenti, MD Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

July 28, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death ecedent's Name (First, Middle, Last) Month BROWN **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1303 Montclair Drive Pasadena Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Sept 22. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Country)
Illinois 1 M 2 € F Ĩ′937 70 319-32-3640 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Anne Arundel Pasadena Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1303 Montclair Drive 21122 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Specify: white altimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 6 radiology transcription healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Hildegard Kongsgard George S. Kleven 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chester Brown/spouse 1303 Montclair Drive Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen State Anatomy Board 655 W. Baltimore Street Baltimore, MD Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part1. Enter the disease, of com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) mon Physician on /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Physician/Medical Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending pl IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has I in by the funeral director, page 2.3 death? 2□ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) ၉ 1 Tyes 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral D

completely filled in 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) ٥ completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

2008

08-05606	
Bertha Bean	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	F	l- For State Registrar		ertificate of	Death		Re	g. No.	00 249
Physicia	n/	1. Decedent's Name (First, Middle,La	st)				 Date of Death Month July 22, 20 		3. Time of Death 1034 hrs
edical Exami		Bertha 4a. Facility Name (if not institution, gi	Bean		b. City, Town, or L	ocation of Death	July 22, 20	4c. County of Death	
		Southern Maryland Hosp		"	Clinton	ocation of beaut		Prince George	
Funeral		5. Social Security Number 6. S		s. last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birtl	h(MM/DD/YYYY) 9. Birt	hplace (State or
Director		241-32-0784	M 2 XF	83 Yrs.	Months Days	Hours Min.	June	2,1925 Foreig	untry) NC
		Usual Residence of Decedent					o dire		
w any		10a. State 10b. County		ity, Town or Location					10d. Inside City Limits 1 X Yes 2 No
Varyland 28a-f show	ē	DC		Washing			100	og. Citizen of What Cour	
ne Maryland or 28a-f sho	Director	10e. Street and Number			10f. Zip Code		100		-
ith the		3629 Suitland 11. Marital Status	Rd., SE	IIS 13 Was	200 Decedent of Hisp	20 panic Origin? (Sp	ecify Yes or No-	United S	tates can Indian, Black,
death with the Maryland ritems 23a or 28a-f she must be notified at once	Funeral	1 Never Married 2 Marrie	ed Armed Forces?	If Ye	es, specify Cuban,	Mexican, Puerto	Rican, etc.)	White, etc.	
after de		3 XWidowed 4 Divorce	1 Yes 2 X No		Yes 2 X No	specify:		Specify: Bla	ck
ours a	d b	15. Decedent's Education (Specify			's Usual Occupations of working life.			16b. Kind of Business/I	Industry
5-0036 led within 72 hours tygiene. other than "natur	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		istrati		·	Dont	of Defense
withingrene.	Ē.	17. Father's Name (First, Middle, Las	2	Admiin		8,Mother's Name			or detense
21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medical	ا به	Thollie Kimb	•			Unk.		,	
AD 21215-0036 2 should be filted within 72 hours h and Mental Hige ne. 27 is marked other than "natur maite event, the Medical Exam	10 B	19a. Informant's Name/Relationship		19b. Mailing	Address (Street	and Number or R	Rural Route Num	nber, City or Town, State	e, Zip Code)
		Eloice Brown/	sister	Wash	ington,	DC 20	ებვნ	100 1 10 00	T O
more, M Pages I and 2 ient of Health int: If item 2		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	b. Place of Dispos crematory or oth	ition (Name of cent ier place)	netery,	Date	20c. Location - City or	Town, State
Pag nent ant:		4 Donation 5 Other Specific	fy: F	t. Linc	oln Cem	1. 7/2	29/08_	Brentwo	od,MD
Baltimore, permit Pages I an Department of Her Important: If ite		21 Signature of Funeral Service Lice	ensee	22. N	ame and Address	of Facility Hoo	dges &	Edwards	F.H.
		23a/Part I. Enter the disease, or con	nnlications that caused the de	139	10 5110	er all.	ra.,	Sultiana,	Approximate Interval
Physician /Medical		Mailure. List only one cause on	each line.						Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence		50101001	.c ourure	71456414	220000	
-		Sequentially list conditions,	b						
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence.	ce of):					
WH: #	xan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):					
760, cate be executed physician and the burial - transit		Yumanan	AMENDED 23a,27	7 ner me	g883 9-1	0-08 vt			-
760, Icate be ex physician the burial	Medical	X UNPENDED			8003 7-1	.0-00 VE		23d. Date of deliver	7
6876 certificat iding physe as the	M/m	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p		tal death 3	Ectopic pregna	ancy		Day Y ear
Box 68's death certificate attending	sician	1 Yes 2 V No 9 Unknow	4 Pregnant at time o	of death 5 Ot	her (Specify)				
D. BC t the der by the a	Phy	Part II. Other significant condition	9 Oliknown	not resulting in the u	inderlying cause o	iven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
P.O. ires that t signed by	ð	, a. m. o. o. o. o. o. o. o. o. o. o. o. o. o.	oo and oo and of the ood				1 Yes	s 2 No 3 Pro	bably 4 🗸 Unknown
rds, require been si hould b	Completed						24a. Was		utopsy findings available completion of cause of
e law 1 e has t gc 2 sh	mpl							rmed? death?	
tal Rection: The certificate ector, page		25. Was case referred to medical			26.Place	of Death (Check		2 10 1	2
Vital Records, sysician: The law requirent in certificate has been siderector, page 2 should be	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	✓ ER/Outpatient	3 DOA	Other Nursir	ng Home 5	Residence 6 Othe	er:
n of ling Ph After t funeral	n: T	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of I		ry at Work?	28d. Describe	how injury occurred	
ion ttendi death. tor: ,	atio	1 X Natural 5 Pending 2 Accident Investig	ation			Yes 2 No			
Division pital or Attendio	ertification:	3 Suicide 6 Could n		At home, farm, stre	et, factory, office b	ouilding, etc.	28f. Location (or Town, S		ural Route Number, City
espita hours uneral	ပ	4 Homicide	ician: To the best of my know	wladge dooth occu	red at the time do	ate and place and	due to the caus	se(s) and manner as sta	ited
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certification within 24 hours after death. The Finneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examin	ner:On the basis of examination	on and/or investiga	tion, in my opinion	n, death occurred	at the time, date	and place, and due to t	he cause(s)
To To	Мес	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	Ti	29d. Date signed (Mo	onth, Day, Year)
		Parasota Buth	of ma		O.C.	M.E.		July 24, 2008	
		30. Name and address of person wh							
		Pamela E. Southall, MD			1 Penn Stree	t, Baltimore, I	MD 21201		
S Regis		31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	47				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Billy 2008 Ox K 2Ó /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12-2-1941 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** Months 217-42-9257 66 Dry Run, MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at MD Washington Clear Spring, 1 ☐ Yes 2 🔀 No 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 14431 Mercersburg Road 21722 U.S.A. Funeral death permit. Pages 1 and 2 should be filed within 72 hours after dea Department of health and Mental Hygiene. Important: If item 27 Is marked other than "natural" any injury or other traumatic events. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married _{Speci}white 1 ☐ Yes 2√2 No Specify: Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Church Elementary/Secondary (0-12) College (1-4 or 5+) Minister 12th grade O 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thelma Blanche Robinson Lloyd Edward Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 14431 Mercersburg Rd.Clear Spring,MD 21722 Dorothy Louise Clark July Date 24 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Clear Spring, MD St.Paul Cemetery 2008 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc 21. Signature Jun ral Service Ligensee P.O.BOX 310 Clear Spring, MD 21722 Approximate Interval Between Onset and Death Part - Enfer the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final failure **Physician** 2 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Cardio myopa Near Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and d for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy signed by the atter Id be detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, should be 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No I or Attending Physician: The law after death.

Director: After this certificate has become a continuate that the continuate has become a continuate that the continua filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SH-12

Marg are 31. Date filed (Month, Day, Year) State JUL 2 2 2008

Johns Hopkin

Hospital

DHMH 17 Rev 1/2001

Registrar

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12, JULY 2008 1701 MAGGIE Ε. CRUTCHFIELD /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGES Cheverly Prince Georges Hospital Ctr 8. Date of Birth (Month, Day, Year) June 20,1928 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 F 80 Director 578-36-4804 Maryland June Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. Counfy 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Silver Spring 1 ∐Yes 2 ∭Mo MD Montgomery Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20903 U.S.A. 8872 Piney Branch Rd, #202 Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 X No Black Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) If item 27 is marked other than "nature or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery Co Elementary/Secondary (0-12) College (1-4or 5+) Custodian Government 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be Raymond Lancaster Ruth Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis Crutchfield (Son) 14700 Winners Ct, Bowie, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other class)

George Washington Date 20a. Method of Disposition 20c. Location - City or Town, State 7/19/08 1 Burial 2 □ Cremation 3 □ Removal from State Adelphi, MD 4 Donation 5 Dother (Specify) 21. Signature / Funeral Service Licen 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 15 months Cardiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Respiratory Failure 3 years Sequentially list conditions, if any, leading to infinishate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit death certificate be executed Chronic Obstructive Lung Disease 15 years P.O. Box 68760. Physician/Medical as attending for use IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) the 9 Unknown signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð Diabetes Mellitus 1 Yes 2 No 3 XProbably 4 Unknown Completed Hypertension 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has b page 2 autopsy performed death? 1 ☐ Yes 2 ☐ No 1□ Yes 2□No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 2€ ER/Outpatient 3 DOA funeral To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1X Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiet Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) JUL 18 2008

6130 Landover Road, Cheverly, MD Revathy Murthy, M.D. 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1	For State Registrar 1. Decedent's Name (First, Middle, Las	it)	-	Certifica			2. Date of D	Reg. No.	2008	2 4 9 5 3. Time of Deat
Physician /Medical			Harry (Cook				Month July	Day 16	Year 2008	4:00 p
Examiner		4a. Facility Name (If not institution, give Suburban F	· · · · · · · · · · · · · · · · · · ·		4b. Ci	ty, Town, or	Location of Death Bethesda	1	4c. Co	ounty of Death Montg	
uneral irector		366-10-1789	ex 7.Age	e (In yrs. last birtl	hday) If Und Month	der 1 Year ns Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D February	ay, Year)		place (State or For ntry) nessee
a-f show		Usual Residence of Decedent 10a. State 10b. County District of Columbia		10c. City, Town	or Location	Washii	ngton				10d. Inside City Lii 1 🛣 Yes 2 🗆
3a or 28a-f sl at be notified		10e. Street and Number 3249 38th	Street, NW		10f. :	Zip Code	20016		10g. Citize	n of What Cou	
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examination and traumatic event, the Modical Examination and To Re Completed by Funeral Director		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent B Armed Forces? 1 ▲ Yes 2 ☐ N If Yes, Give	No		cedent of Hipecify Cubar	spanic Origin? (S n, Mexican, Puerto Specify:	pecify Yes or N o Rican, etc.)		. Race - Ameri Black, White, pecify:	
"natural", o dical Exer affed by		3 🗷 Widowed 4 ☐ Divorced 15. Decedent's Ed (Specify only highest gra	Year or Dates:	1941-1945	Decedent's U	sual Occupa work done d	ation uring most of wor	king		of Business/Ir	aucasian dustry
Important: If item 27 is marked other than "natura any injury or other traumatic event, I'v. I'v. Included once. To Be Commission		Elementary/Secondary (0-12)	College (1-4or 5	i+)		iness (D wner			Retail	Liquor
arked oth atic even To Re	۵	17. Father's Name (First, Middle, Last)	ouis Polk				18. Mother's Nam		e, Maiden Su e instein		
is mar aumati T		19a. Informant's Name/Relationship (19b.	Mailing Addre	ess (Street a	ınd Number or Ru				p Code)
m 27 her tr	-	Michael Cook -	Son				Road, Ro				own State
ant: if fte ury or ot		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ⊠ 4 ☐ Donation 5 ☐ Other <i>(Specif</i>)		20b. Place of cemeters King Dav			i .	Date 21/2008		tion - City or To	Virginia
Import any inj once.		21. Signature of Europeral Solvies Licen	see		Hines-	and Addres Rinaldi	s of Facility i Funeral l apshire Av e	Home, Inc	ver Spr	ing Mar	vland 2090
sician edical miner	1	23a. Part 1. Enter the disease, or company shock, or heart failure. List only disease or condition resulting in death)	one cause on each ling.	ne.		node of dying	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Deat 1 week
ng physician and sas the burial-transit	LXG	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (prease or injury) that initiated events resulting in death) Last	C	a consequence o	<i>'</i>						
etached for use as the property of the propert		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □ Ectopi 5 □ Other	c pregnancy (specify)			234	d. Date of deliv	very Day Yea
e ge	5	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in	the underlying	g cause give	n in Part I.				the cause of deat
or, page 2 should		25. Was case referred to medical						peri 1 □ Yes	2 🗷 No	24b. Were aut prior to co death? 1 ∐Yes	opsy findings avai ompletion of caus 2 □ No
ral director, p. To Be C	2	examiner? 1 ☐ Yes 2 🕱 No		ent 2 ER/Out	<u> </u>		4 LI Nursing h	lome 5 ☐ Res	sidence 6 [ify)
or: Affe	Cation	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	1	y, Year) 28b. T.	njury M		rat ? ∕es 2 ∐No	28d. Describe			 ral Route Number
		4 ☐ Homicide determined 29a, Certifier 1 ☒ Certifying Ph	building, etc ysician: To the best	c. (Specify)			ne. date and place	City or To	own, State)		
o the Fune ompletely fi) -	(Check only 2 Medical Exam	niner: On the basis of and manner sta	f examination and	d/or investigat	ion, in my op	pinion, death occu		e, date and p	lace, and due	to the cause(s)
28 =		29b. Signature and title of certifier	_ WIN			29c. License	D0060117		29d. Date :	signed (Month	
	-	30. Name and address of person who	11100			Pood P	sthoods W	aryland f)AQ1 /.	-	
State		Eric Joon-Shik Park 31. Date filed (Month, Day, Year)		ar's Signature	Society	~	emesua, M	arytang 2	.0014		

DHMH 17 Rev 1/2001

116/08 2+Pm

COOK, HARRY T.O.D

			1 - For State Registrar	State of M	laryland / [rtment of			lental H	ygiene Reg. No		8 C	24	952
	Discort		1. Decedent's Name (First, Middle,	Last)						2. Date of D	eath			3. Time o	f Death
	Physic /Medi		Ela	Marie			Denni	s		Month July	2 1		Year 008	7:05	P M
	Exami		4a. Facility Name (If not institution,	give street and number)			4b. City, Town	n, or Locati	ion of Death		4c. County of Death				
		_	NMS Health Care				Hagers			Washingt			ingt	on	
* 3	Funeral Director		5. Social Security Number 235–82–4370	5. Sex 7. Ag 1 ☐ M 2 ∏ F	ge (In yrs. last bii	rthday) Yrs.	If Under 1 Ye Months Day		der 24 Hrs. rs Min.	8. Date of B	ay, Year,	, , , ,		lace (State of	or Foreign
	7		Usual Residence of Decedent		82					Sept.	ا و ۱۱	1925	Per	u	-
	nylan ihow	_	10a. State 10b. County		10c. City, Tow	n or Loc	ation						1	0d. fnside C	ity Limits
	Ba-f s	cto	FL Leon		Tallah	asse	ee							1 🗌 Yes	2 X No
	or 2	Director	10e. Street and Number				10f. Zip Code					itizen of Wi	hat Cour	try?	
	s 23s	ral	3077 Crump Road				323					Peru			
36	be filed within 72 hours after death with the Maryland hat Hygiene. Id other than "natural", or items 23s or 28s-f show event, it a Modical Exerting transite notified at	by Funeral	Narital Status Never Married 2 Married Midowed 4 Moivorced	12. Was Decedent Armed Forces? 1 Yes 27 I If Yes, Give Year or Dates:		_	/as Decedent of Yes, specify C		nih.e.		10-	14. Race Black, Specify:	, White,	etc.	
9	2 hours	edt	15. Decedent's		16a	Decede	ent's Usual Occ	cupation	Peri	ıvian	16h K			panic	
215	in 72 in "nat	Completed	(Specify only highest	grade completed)		(Give ki	ind of work dor O NOT use ret	ne durina n	nost of work	ng	160. K	(ind of Bus	iness/inc	iustry	
212	d within giene. or than "	E	Elementary/Secondary (0-12)	Coflege (1-4or 5		urgi	lcal Nu	rse			Mr	dica	L		
p	be filed tal Hygie d other l	Be	17. Father's Name (First, Middle, La	st)				18. Mc	other's Name	(First, Middle	e, Maiden	1 Surname,	J		
yla	ould be Mental arked c	2	Unknown					Un	known						
Maryland 21215-0036	d bus E		19a. Informant's Name/Relationship		196	. Mailing	Address (Stre	et and Nu	mber or Rura	I Route Numb	ber, City o	or Town, S	tate, Zip	Code)	
e)	1 and 1ealth im 27 thar t	1	Joseph M. Dennis 20a. Method of Disposition	s, Sr./Son			Crump R	load,		-		323			
Baltimore,	ages or of the		1 ☐ Burial 2 ☑ Cremation 3		cemeter	ry, crema	tion (Name of atory or other p	,	1	late		ocation - C			
臣	it. Partme		 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Light 		Smiths	-	g Crema		1			Lthsbu	-		
Ba	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 li any injury or othar tra ances.		> Sarule S	sem-)1 Penn							-	12
280	.e.		23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused	the death. Do r									Approximate	
. 70	Physician		Immediate Cause (Final disease or condition	a. COVA SA 6	avu A	41	ern 1	1 Se						Onset and I	ween
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	U							7	-
		0	Sequentially list conditions if any leading to immediate		a consequence	of):								SX	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 (0) (0)	a consequence (017.									
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99	ntifica ng ph	Med	IE ECMAI E.												
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0	the all	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown			Other (specify)					Month	1	Day Y	/ear
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æ	The law ate has page 2:	E O								auto	psy ormed?	prio	or to com th?	pletion of ca	iuse of
ā		a	25. Was case referred to medical					26 Pla	ace of Death	1 ☐ Yes (Check only o	25 No	1 1	Yes :	2□ No	
>	dis y	ToB	examiner? 1 🗆 Yes 255 No	Hospital: 1 Inpatier	nt 2 ER/Out	tpatient	3 DOA	Note and		ne 5 ☐ Resi		6 □Other	(Specify		
0	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of fnjur (Month, Day	y 28b. T	ime of	28c. Inj			8d. Describe					
Sio	Attending ir death. ector: Alter by the fune	catl	2 Accident investigati	on			M 1[☐Yes 2	□No						
Σ	를 들는 를	Certification;	4 Homicide determine		ury - At home, far c. (Specify)	rm, street	t, lactory, office	θ	2	8f. Location (City or To	Street and wn, State,	d Number (or Rural	Route Numb)Br,
_	Hospital Puns S Funeral I tely filled		29a. Certifier 1 Certifying F	Physician: To the best of	of my knowledge	doath o	and and the	turna alata	and alarm	-11					
	To the Hospital within 24 hours a Fo tha Funeral completely filled	edical	(Check only 2 Medical Exa	aminer: On the basis of and manner stat	examination and	dor inves	stigation, in my	opinion, d	and place, a leath occurre	d at the time,	date and	and mann place, and	er as sta due to	ted. the cause(s)	
	vithin 24 To the F complete		29b. Signature and title of certifier			-	29c. Licer	nse numbe	er		29d. Date	te signed (f	Month, D	ay, Year)	
				2				255	スフ	5	67_	-72-	-20	08	
. 21	1 2		30. Name and address of person who	completed cause of de			int)						-	- 3	
91	1-5		Khalid Waseem			Opa	1 Cour	t, Ha	gerst	own, MI) 2	21742			
	Sta Registra		31. Date filed (Month, Day, Year) JUL 2 3	N/	r's Signature	Sou	we								

			For State	State of Mary		partment of F Certificate of			giene Reg. No. 20 (08 24953
			Registrar Decedent's Name (First, Middle, La	ist)		er tillcate or	Deain 	2. Date of De	ath	3. Time of Death
	Physicia /Medic		SPENCENA	M. DE	JESUS			July	11, 2008	8 7:55A M
100	Examin		4a. Facility Name (If not institution, give	ve street and number)		4b. City, Town, o	r Location of Deat		4c. County of	
A.			Shady Grove A				ville			gomery
	Funeral Director		439-24-0178	Sex 7. Age (In 1	yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.		, 1925	Birthplace (State or Foreign Country) LA
	and		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town o	Location				10d. Inside City Limits
	Mary a-f sh	tor	MD Montge	omerv	Mont	gomery V	illage			1 X Yes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	ath wi		20405 Studio			2088			U.S.	.A.
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanther must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1	in U.S.	 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No 	lispanic Origin? (S an, Mexican, Puerl Specify:	Specify Ye's or No to Rican, etc.)		American Indian, White, etc. Black
2-0	72 ho	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. De	ecedent's Usual Occup	pation during most of wor	rkina	16b. Kind of Busin	ness/Industry
21215-0036	within jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	li	e. DO NOT use retired autician	i) , , , , , , , , , , , , , , , , , , ,	g	Privat	te
pu	al Hyg	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nar	me (First, Middle,	, Maiden Surname)	
yla	should be ind Mental marked c	ပ	Herbert Nevea					rtine :		
Baltimore, Maryland	and 2 shealth and n 27 is n		19a. Informant's Name/Relationship (Edward DeJesus:		- 1	ailing Address <i>(Street</i> :05 Studi				
ore,	es 1 a of Hea fitem rothe	1	20a. Method of Disposition	20	Db. Place of Di cemetery,	sposition (Name of crematory or other place	ce)	Date	20c. Location - Cit	ty or Town, State
Ĕ	Pages tment of I tant: If ite		11 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Conation 5 ☐ Other (Special	fy 7		uls Cem	7/1	8/08		own, MD
Bal	permit. Departr Importa any injt		21. Si may re of Funeral pervia Lice	nonden	L					Home, PA Le, MD 20 850
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only	one cause on each line	4			c or respiratory a	rrest,	Approximate Interval Between Onset and Death
100	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		estinal	bleed			Nours
r	Examiner			Due to (or as a cor	isequence of):					
	D ±	ner	Sequentially list conditions, if any, reading to himsedate cause. Enter Underlying	b. Due to forces a our	sequence of:					==
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68760,	lificate be executed g physician and as the burial-transit	calE		d	isequence on).					
		Medical								
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use as a second page.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pro 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		23d. Date o Month	
S, G,	ires that the de signed by the a be detached f	Ď.	Part II. Other significant conditions of	contributing to death but not	resulting in th	e underlying cause give	en in Part I.			ute to the cause of death?
Š	w require s been sig should b	eted		ation	-				Yes 2 No 3[
Vital Records,	scertificate has lirector, page 2 s	Completed						24a. Was autop perfo 1 ∐Yes	osy prio dea	re autopsy findings available or to completion of cause of th? IYes 2 □ No
<u> </u>	slciar certif	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		tiont 3 DOA Oth		ith <i>(Check only o</i>		
Division of	ding Phys h. After this funeral din	ion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Yea	28b. Tim	e of 28c. Injur	y at	T	dence 6 Other ((Specify)
Visio	al or Attend after death Director: /	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e Rea Place of Injury	At home, farm,		Yes 2 □No	28f. Location (S City or Tov	Street and Number of	or Rural Route Number,
ā	pital or rurs afte eral Dir filled in					and the second second			-	
	To the Hospital of within 24 hours at To the Funeral D completely filled i	edical	29a. Certifier 1 ☐ Certifying Pt (Check only one) 2 ☐ Medical Exam	nysician: To the best of my niner: On the basis of exal and manner stated.	mination and/c	r investigation, in my o	pinion, death occu	e, and due to the urred at the time,	date and place, and	er as stated. If due to the cause(s)
	To the within 2 To the comple	Ň	29b. Signature and title of certifies	D.S)	29c. Licens	e number	7	29d. Date signed (A	Month, Day, Year)
	V		30. Name and address of person who	completed cause of death	(Item 23a) (Typ	1 4 7 1	Gaithe	cshura	W7	1 2000
	Sta	e	31. Date filed (Month, Day, Year)	32. Segistrar's S		partie	0 000010	300.9	10.	
	Registra	ar	.1111 182	008 Brew	10. V					

				artment of F ertificate of		- 0	iene eg. No.2 () (08 24954
	Physici /Medi		1. Decedent's Name (First, Middle, Last) DONALD E . DORSEY SE	₹		2. Date of Deat July	1 ^{Pay} , 20	3. Time of Death 4:40A M
	Examir		4a. Facility Name (If not institution, give street and number) Apex Nursing Home		r Location of Death	J	4c. County of	Death
4	Funeral Director		5. Social Security Number 219-34-7793 6. Sex 1 M 2 F 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Bay, Apr 8	1°9′39	D. Birthplace (State or Foreign
	show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		1.		10d. Inside City Limits
	the Mar 28a-fs	Funeral Director	MD Montgomery Gait 10e. Street and Number	hersbur	g	10	Og. Citizen of Wh	1≹Yes 2 No
	ath with s 23a o	ral D	20533 Zion Road	2087			U.S.	Α.
036	urs after de al', or items Examiner m	þ	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. Black
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest grade completed) (Give	edent's Usual Occup e kind of work done o DO NOT use retired nter	pation during most of worki d)	ing	16b. Kind of Busin	ness/Industry
land 5	uld be filed v fental Hygie rked other I tic event, th	To Be Co	12th Pri 17. Father's Name (First, Middle, Last) William Dorsey	.iicer	18. Mother's Name	e (First, Middle, Nangline	laiden Surname)	
Mary	nd 2 shou Ith and N 27 Is mai	_			and Number or Rura			
ore,	ges 1 ar t of Hea If item 2 or other			osition (Name of ematory or other place			20c. Location - Ci	
Baltimore,	permit. Par Departmen Important: any Injury once.	4	4 □ Donation 5 □ Other (Specify) 21. Signature of Funerat Service Licensee 2	2. Name and Addres		nowden	Funera.	rsburg, MD l Home, PA e ,MD20850
	Physician		23a. Part1. Enter the disclase, or complications that caused the death. To not en shock, or heart faire. List only one cause on each line. Immediate Cause (Final disease or condition esulting in death) a. Alzheimer	ter the mode of dyin	ng, such as cardiac o			Approximate Interval Between Onset and Death
8760,	Medical Examiner bhysician and sthe burial-transit	dical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to limit and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):					
O. Box 6	eath certif attending for use as	Physician/Med		⊒Ectopic pregnancy ⊒ Other (specify)			23d. Date of Month	-
rds, P	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the under the conditions of the conditions contributing to death but not resulting in the under the conditions of the conditions contributing to death but not resulting in the under the conditions of t				acco use contribu	ute to the cause of death?
Vital Records,		Completed	failure to thrive, Hyp. Heart disease	utens;	n	24a. Was an autopsy perform 1 Yes 2	r prio	re autopsy findings available r to completion of cause of th? Yes 2X No
ō	Attending Physician: r death. ector: After this certific by the funeral director,	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatier 27. Manner of Death Shatural 5 Pending investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	f 28c. Injury Work	4 Nursing Hon	(Check only one ne 5□ Resider 28d. Describe how	nce 6 □Other	(Specify)
DIVISION	To the Hospital or Atter within 24 hours after dea To the Funeral Directo completely filled in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str building, etc. (Specify)			City or Town,	State)	or Rural Route Number,
	he Hosp n 24 hou he Fune pletely fi	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the tim vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the car ed at the time, da	use(s) and mannete and place, and	er as stated. I due to the cause(s)
,	Within Com	Ĭ	29b. Signature and title of certifier Chowdly	29c. License	3/21		7/17/0	Month, Day, Year)
	V		30. Name and address of person who ampleted cause of death (Item 23a) (Type, NURUL CHOWDRURY, MD; 15216	Print) DINO DRI	VE; BUR	TONSVI	LLE, M	020866
ï	Sta Registr	80	31. Date filed (Month, Day, Year) JUL 2 1 2008 32 Registrar's Signature	edi.		*		

	en fan	State of Maryland / E	Department of Health and I Certificate of Death	Mental Hygiene Reg. No	2008 24955
Physic	cian	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	y Year 3. Time of Death
/Med		James Wilbur Estep, Sr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deatl	July 16,	County of Death
Exam	iner	Holy Cross Hospital	Silver Spring		Montgomery
F-1111		5. Social Security Number 6. Sex 7. Age (In yrs. last bir.	thday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign
Funera Directo		577-10-9226 1⊠M 2□F 88	Yrs. Months Days Hours Min.	Dec. 9, 19	19 D.C.
D		Usual Residence of Decedent 10a State 10b County 10c City, Town	and anotion		10d. Inside City Limits
rylan	_	10a. State 10b. County 10c. City, low	TOI LOCATION		1 ☐ Yes 2 🛣 No
e Ma	Director	114119 114111	Silver Spring 10f. Zip Code	10a. Ci	itizen of What Country?
vith th	i i	10e. Street and Number	20906		USA
s 238	era	12728 Gould Road 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	specify Yes or No-	14. Race - American Indian,
filed within 72 hours after death with the Maryland Hygiene. Hygiene. The "natural", or items 23a or 28a-f show ent, the Mexical Examiner must be refilled at	Funeral	1 Never Married 2 Married 1 X Yes 2 No	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, etc.
al", or	ò	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1941-45	1 ☐ Yes 2 ⊠ No <i>Specify:</i>		Specify: White
2 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of wo		Kind of Business/Industry
ithin 7	햩	Elementary/Secondary (0-12) College (1-4or 5+)	<pre>life. DO NOT use retired)</pre> <pre>partment Head, Tariff</pre>	Division Fe	deral Government
led will her the	ទី		1	me (First, Middle, Maide	
be fill he dot	Be	Coorgo W Esten	Arlene	Carrico	
Lal ylalla 2.12 2 should be filed withi and Mental Hygiene. is marked other than aumatic event, Ithe M	은	19a. Informant's Name/Relationship (Type. Print) 19b	b. Mailing Address (Street and Number or R	ural Route Number, City	or Town, State, Zip Code)
od 2 s Ith an 27 is i		Total information of the control of	12728 Gould Road, Si		
is 1 and 2 should be filed within 72 hours after death with the Marylan is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. I tiem 27 is marked other than "natural", or items 23a or 28a-f show rother traumatic event, the Medical Examiner must be rectified at		20a. Method of Disposition 20b. Place of comments	of Disposition (Name of	Date 20c. l	Location - City or Town, State
		V Vousial 2 Cremation 3 Hemoval from State	0	uly 22 2008 Ro	ckville, Maryland
⊒ ± € € €	once	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Francis J. Collins 500 University Bly	Funeral Ho	me Inc. er Spring, MD 20901
		23a. Part 1. Enter the disease, or complications that caused the death. Do			Approximate Interval Between
Physicia /Medica	al	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiogenic St Due to (or as a consequence			Onset and Death
Examine		Sequentially list conditions, b. Cardiomyopath Due to (or as a consequence			
ted nsit	Examiner	Sequentially list conditions, it is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injusted eyents) Coronary Arter	•		
execunate and al-tra	Exai	that initiated events c. COFORATY AT CEST presulting in death) Last Due to (or as a consequence	of):		
or ou, cate be executed physician and the burial-transit	dical				
certificat certificat nding phy	ledi				
box od eath certifice attending pt for use as th	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?	th 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
. 0 60	Sici	In the past 12 months? 1	5 Other (specify)		
Hecords, P.O. The law requires that the deate has been signed by the page 2 should be detached	P S	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
dS, ires th signe	2	Cellulitis of Left Leg. Congestive		1 ☐ Yes	2X No 3 Probably 4 Unknown
requ been should	Completed			24a. Was an	24b. Were autopsy findings available
VITAL HEC sician: The law certificate has lirector, page 2 s				- autopsy performed? 1 □Yes 2 🔀 I	prior to completion of cause of death?
tal In: TI Ufficate or, pa	ا ا		26. Place of D	eath (Check only one)	10.00 10.00
/sicia /sicia s cerr	8	examiner?	Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)
g Physeral	ءِ ا	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 ★ Natural 5 Pending	Time of 28c. Injury at Work?	28d. Describe how in	jury occurred
ath. Pr: Af	iti	13 Natural 5 Pending (World, Day, Tear) 2 □ Accident investigation	M 1 □Yes 2 □No		D. (D. d. North
Division of Vital Records, al or Attending Physician: The law requires t s after death. al Director: After this certificate has been signe al Director; After this certificate has been signe al of the funeral director, page 2 should be e	Cortification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined building, etc. (Specify)	farm, street, factory, office	City or Town, St	and Number or Rural Route Number, ate)
pital o	5		ge, death occurred at the time, date and pla	ice, and due to the cause	e(s) and manner as stated.
DIV To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ledical	29a. Certifier (Check only one) 11x Certifying Physician 10 the best of my knowled one one of the physician 10 the basis of examination and manner stated.	and/or investigation, in my opinion, death or	curred at the time, date	and place, and due to the causo(s)
To the within Fo the complex	Mo	29b. Signature and title of certifie	29c. License number		Date signed (Month, Day, Year)
		1	D00628	325 Au	igust 15, 2008
		30. Name and address of person who completed cause of death (Item 23a Atul H. Suri, MD 7523 Hanover	a) (Type, Print) Parkway, Greenbelt,	MD 20770	
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	· Landa		
Reg	istra	SEP 0 2 2008 Research	HORACI		

			State State Amend Items 19a, b	of Maryland / per inf.,g	Depa Cer	rtment of H 05/11/20 tificate of L	ealth and N l I dhb Death	/lental Hyg	iene 2 C	008	24956
			1. Decedent's Name (First, Middle, Last)					2. Date of Dear Month		Year	3. Time of Death
	Physicia /Medic		Jerome	Foot	er			July 17		Teal	5:00 A M
	Examin		4a. Facility Name (If not institution, give street and	f number)		4b. City, Town, or			4c. County	of Death	
À			5. Social Security Number 6. Sex	7. Age (In yrs. last t	airth day)	Rockvi	11e If Under 24 Hrs.	8 Date of Birth		omery	ace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 M № 2 □		Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day May 4,	Year) 1921	Counti	<u>y</u>)
			Usual Residence of Decedent					riay +;	1,721		
rylan	how	_	10a. State 10b. County	10c. City, To	wn or Loc	cation				10	d. Inside City Limits
ie Ma	8a-f s	Director	MD Montgomery	Rocky	/ille	· · · · · · · · · · · · · · · · · · ·					1K Yes 2 No
with th	a or 2	ä	10e. Street and Number	/1000		10f. Zip Code		1	0g. Citizen of \		'Y?
G Z IZ I 3-0030 filed within 72 hours after death with the Maryland	ntal Hygiene. od other than "natural", or items 23a or 28a-f show event, The Medical Evarning must be rudified at	Funeral	5801 Nicholson Lane 7	F1802 Decedent Ever in U.S.	13. V	20852 Vas Decedent of Hi	spanic Origin? (Sr	ecify Yes or No-	U.S.	A • ce - America	n Indian.
fter d	r iten	ᇤ	1 Never Married 2 ☑ Married 1 ☑ Y	d Forces? es 2□No Navy	"	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		ck, White, et	
DOUS a	er, o	β		, Give or Dates: WWII	1	∐Yes 2 k No	Specify:		Specify	Whit	te
가 2	inatur dice	Completed	15. Decedent's Education (Specify only highest grade complete		(Give I	lent's Usual Occupa kind of work done o	luring most of work	ring	16b. Kind of B	usiness/Indu	ustry
it i	han "	ם	Elementary/Secondary (0-12) College	ge (1-4or 5+)		OO NOT use retired,)		D t-	_ 1	
iled v	Hygie ther t		17. Father's Name (First, Middle, Last)	5+ De	entis	S T	18. Mother's Nam	e (First, Middle,	Dent Maiden Surnan		
d be	ental ced o	o Be	Albert Footer					Krupnick		,	
ar y	mari mari	은	10a Informant's Nama/Rolationship (Time Print)	19	9b. Mailin	g Address (Street &			r, City or Town,	State, Zip	Code)
Nd 2	alth a 27 is er trau	100	Beverly L Footer Beverly D. Footer	Vife 58		icholson	4	02	kville,	_	
s 1 a	item item		20a. Method of Disposition	20b. Place		sition (Name of natory or other place		Date	20c. Location -	City or Tov	vn, State
altımor rmit. Pages	ant: If		1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal fi 4 ☐ Donation 5 ☐ Other (Specify)	om State		d Mem. Gd	:	1/08	Falls C	hurch,	, Virginia
permit.	Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Magnee.		21. Signature of Funeral Service Licenses		- Ed	Name and Address ward Sage 91 Rockvi	el Funera	1 Direct	ion, I	nc. D 208	52
			23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause	nat caused the death. D							Approximate Interval Between
Ph	ysician		Immediate Cause (Final	Lzheimer's I)ises	150					Onset and Death
1	Medical		resulting in death)	e to (or as a consequenc		100					
E	kaminer	L	Sequentially list conditions. b								
pe	sit	ine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury)	e to (or as a consequenc	e of):						
xecut	and I-tran	Examiner	that initiated events c	e to (or as a consequenc	e of):						
ate be ex	physician and the burial-transit				,						
00/	g phys	edical	d								
ath cert	n. After this certificate has been signed by the attending I funeral director, page 2 should be detached for use as	Physician/Me		, outcome of pregnancy		le			23d. Da	ite of deliver	ry
deat deat	e atte	icia	1 Dyes 2 DNo	live birth 2☐ Fetal dea Pregnant at time of death Jnknown		Ectopic pregnancy Other (specify)	/		Me	onth I	Day Year
t the C	by th tache	hys	9 Li Unknown	-							
o, i	igned be de	by F	Part II. Other significant conditions contributing	to death but not resulting	in the ur	iderlying cause give	en in Part I.				e cause of death?
ecords, law requires t	een s	ted	Spinal Stenosis					1 1 1			ably 4 ☐ Unknown
law law	nasb e 2 st	Completed						24a. Was a autop	in 24b.	Were autop prior to con	sy findings available apletion of cause of
The	cate,	S						perfor 1 □ Yes	ned? 2 K No	death? 1 ☐ Yes	2 □ No
VICAL ician: 1	certifi	Be	25. Was case referred to medical examiner? Hospital:			Tothe	26. Place of Dea	,			
OI Phys	this ral dir	은	I res 2 X No	1 ☐ Inpatient 2 ☐ ER/ Date of Injury 28t	Outpatien Time of		4 🗆 Nursing n	ome 5X Resid)
ding	h. After funei	li o	1 Matural 5 ☐ Pending	Month, Day, Year)	Injury	Work	Yes 2 □No	200. Describe ii	ow injury occur	iou .	
VISION OF	deatl ctor: y the	fical	2 - Noodelite Could not be	lace of Injury - At home, building, etc. (Specify)	farm, stre		.00 12	28f. Location (S	treet and Numi	ber or Rural	Route Number,
<u>ا</u> و	after death. I Director: After to d in by the funera	Certification: To	4 ☐ Homicide determined	oullding, etc. (Specify)				City or Tow	n, State)		
UIVISION OF VITAL RECORDS, F.O. BOX 00/00, the Hospital or Attending Physician: The law requires that the death certificate be executed.	within 24 hours after deatled the Funeral Director: Completely filled in by the	Medical C	29a. Certifier (Check only one) (Check only one) (Check only one)								
o the	of the	Mec	29b. Signature and title of certifier			29c. License	e number		29d. Date signe	ed (Month, E	Day, Year)
*	10		Same, o			D472	39		July 17	. 200	8
***	AL IV		30. Name and address of person who completed	cause of death (Item 23a	a) (Type,					, 200	<u> </u>
			Jerold M. Share, MD	3301 New Me			36 Wash:	ington,	DC 2001	.6	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Egistrar's Signature							
	Regist	ar	JUL 2 1 2008	Bolive S.	1	ABAGE!					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month /Medical 4a. Eacility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c County of Death Examiner edi 0 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 🔀 M 2 🗆 F Days Hours Min. Director 70 578-50-3648 July 15,1938 Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Directo DC Washington 10e. Street and Number 10g, Citizen of What Country? 244 Division Ave., NE20019 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. Black, White, etc. 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced 'natural' 16a. Decedent's Usual Occupation Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cook Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If item 27 is marked of any Injury or other traumatic even Samuel Ferguson Sr Mary Meek ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4612 Argyle Terrace, NW Washington, DC 20011 20b. Place of Disposition (Name of cernetery, crematory or other place) 8/4/08 Barbara Ferguson/sister 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/4/08 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cemetery Suitland, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licenses 3910 Silver Hill Rd., Suitland, Md. 23a. Part. Inter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ships or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trar Due Division or Vital Records, P.O. Box 68760 Physician/Medical the for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown ģ page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Certification: To 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 □ No 2 ☐ Accident 6 Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Birthplace (State or Foreign Country)

Wash., DC

Black

10d. Inside City Limits

1 XYes 2 No

20746

Approximate Interval Between Onset/and Death

0×1

Year

Month

within 24 hours after death To the Funeral Director: completely

21202

State

Registrar

MY

32. Registrar's Signature

08-05622 Anita Groover Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

8

Anita Grodver		State of Maryland / De- For State (Registrar	Certificate of			. No. 21	08 21.95
Physici Medical Exami	an/	1. Decedent's Name (First, Middle,Last) ANITA GROOVER			2. Date of Death Month July 23, 200	Day Year	3. Time of Death 0056 hrs
/		4a. Facility Name (if not institution, give street and number)	41	o. City, Town, or Location of	f Death	4c. County of Deat	h
Forest		815 Hayward Avenue 5. Social Security Number 6. Sex 7. Age (In)	yrs. last birthday)	Takoma Park If Under 1 Year If Under	r 24Hrs. 8. Date of Birth	Montgomery (MM/DD/YYYY) 9. Bi	rthplace (State or Foreign
Funeral Director		217-06-1940 1_M 27F 37	•	Months Days Hours	_	Co	ash., D.C.
/ any		Usual Residence of Decedent 10a. State 10b. County 10c.	. City, Town or Locatio	on			10d. Inside City Limits
/land -f show	ē	Maryland Montgomery 10e. Street and Number	Takoma Par	k 10f. Zip Code	110	g. Citizen of What Cou	1 X Yes 2 No
566 th the Mary 23a or 28a notified at	Director	815 Hayward Avenue		20912		USA	, .
Z S	eral I	11. Marital Status 12. Was Decedent Ever		Decedent of Hispanic Drig s, specify Cuban, Mexican	in? (Specify Yes or No-		rican Indian, Black,
er death	Funeral	1 Never Married 2 Married 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year	No	Yes 2 No specify:			Black
ours after authornal"	िक	15. Decedent's Education (Specify only highest grade complete	ed) 16a. Decedent	's Usual Occupation (Give	kind of work done	16b. Kind of Business	
16 n 72 hc nan "ng ical Ex	olete	Elementary/Secondary (0-12) College (1-4 or 5+)		est of working life. DO NDT NM ASS't	use retirea)	Montgomor	ry College
Paltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show in Jury or other tranumatic event, the Medical Examiner must be notified at once.	Completed	12th TUO 17. Father's Name (First, Middle, Last)	Trogra		's Name (First, Middle, M		y College
21215 21215 201d be file 1 Mental H 1 marked of	Be	Clarence Groover, Sr.	100 11 00		Vettie Reese		7:- 0-4-)
ID 2. should and Maric en	입	19a. Informant's Name/Relationship (Type, Print) Clarence Groover, Sr./fathe:		Address (Street and Nunnyward Avenue			1
Ce, N 1 and 2 Health Fitem 2		20a. Method of Disposition		tion (Name of cemetery,	Date	20c. Location - City of	
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumatinjury or other traumatin		4 Dollation 5 Other Specify.	Maryland N	Mat'1 Cem.	07-28-2008	Laurel, M	Maryland
Balti permit. Departr Import		21. Signature of Funeral Service Licensee	10110	ame and Address of Facility edar Hill FH		Cui+1on	.d MD 207/6
Physician		23a. Part I. Enter the disease, or complications that caused the	death. Do not enter th	e mode of dying, such as o	ardiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
'Medical	8	failure. List only one cause on each line. Immediate Cause (Final disease a. Cardiac arr					Death
,		or condition resulting in death) Due to (or as a conseque b. Dilated cad	the second of the second	with myocard	ial fibrosis	3	
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ince of):				
id	Examine	(Disease or injury that initiated events resulting in death) Last	ence of):				
68760, certificate be executed nding physician and se as the burial - transi	Medical	X UNPENDED AMENDED Line	a-b,PII,	27,perME, G88	32 8/8/08 TT	[
3760, ificate be upplysicing physicins supplysicing	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth		tal death 3 Ectopi	c pregnancy	23d. Date of delive Month	ery Day Year
Box 687 death certific the attending p	Physician/I	past 12 months?		ner (Specify)			•
). BC: the dest by the s	Phy	y diknowi	t not resulting in the u	nderlying cause given in P	art I. 23e. Did to	bacco use contribute t	to the cause of death?
Division of Vital Records, P.O tal or Attending Physician: The law requires that t is after death. an Director: After this certificate has been signed by led in by the funeral director, page 2 should be detected.	d by	Obesity; asthma					obably 4 V Unknown
ords w requ as been should	Completed				24a. Was a autop: perfor	sy prior to	autopsy findings available of completion of cause of
Rec The la ficate h	Com			26.Place of Death	1 ✓ Yes		
/ital /sician:	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatient	Other		Residence 6 🗸 Oth	ner: Scene
r of \ ing Phy After th	ı,	27. Manner of Death 28a. Date of Injury	28b. Time of I		_	now injury occurred	
Sion Attend death.	catio	1 X Natural 5 Pending Investigation 28e Place of Injuny	At home farm stre	1 Yes 2 et, factory, office building, e		Street and Number or I	Rural Route Number, City
Divis Hospital or A 24 hours after Funeral Dire	Certification:	3 Suicide 6 Could not be determined (Specify)	- Actions, lam, or or	s, ideas, i embe benenigi e	or Town, S		
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Directors. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical C	29a. Certifier 1 Certifying Physician: To the best of my kn one) 2 Medical Examiner: On the basis of examina	owledge, death occur ation and/or investiga	red at the time, date and plation, in my opinion, death o	ace, and due to the caus	e(s) and manner as st and place, and due to	ated. the cause(s)
To To con	Mec	and manner stated		29c. License number		29d. Date signed (A	fonth, Day, Year)
		laid Hallan	-	O.C.M.E.		July 23, 2008	
CA		30. Name and address of person who completed cause of death Carpl Allan, MD Assistant Medical Examin		Street, Baltimore, Mi	D 21201		
	state	31. Date filed (Month, Day, Year) 32. Registrar's S	Signature				
Regi	STEEL	1111 3 0 2008 Renew 15					

			1 - For State Registrar	State of Marylan		artment of rtificate of			iene eg. No. 20	08 24959
	Physici /Medic Examir	al	Decedent's Name (First, Middle, L Mangaret Vingir A. Facility Name (If not institution, gi	nia Guessford		4b. City, Town,	or Location of Dea	2. Date of Deal Month July	Day	3. Time of Death Year 2008 9:49 A M
	Funeral Director	iei	7 Red Men Alley	Sex 7. Age (In yrs	Yrs.	Will If Under 1 Yea Months Days	iamsport	s. 8. Date of Birth	Wa Year)	ashington 9. Birthplace (State or Foreign Country) Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28e-f show any injury or other traumatic event, the Marical Examination intelligible and once.	To Be Completed by Funeral Director	10a. State 10b. County Maryland Washir 10e. Street and Number 7 Red Men Alley 11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced 15. Decedent's E (Specify only highest g) Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Laster Leslie C. Hawks. 19a. Informant's Name/Relationship Patty A. Everitt 20a. Method of Disposition XABurial 2 Cremation 3 4 Donation 5 Other (Spec	12. Was Decedent Ever in U. Armed Forces? 1	16a. Dece (Give life.) 19b. Mailir 10 A lace of Dispoemetery, crere	Was Decedent of If Yes, specify Culting Address (Street S. Conoc sittion (Name of matory or other plane).	21795 Hispanic Origin? Jan, Mexican, Pue Specify: pation d during most of w dd) fe 18. Mother's N Ethel t and Number or F Ocheague ace) IR July unærally H	Specify Yes or No- into Rican, etc.) orking ame (First, Middle, I I rene Haw Rural Route Number St. Will Date 23,2008 ome, F.A.	Black Specify: 16b. Kind of Bus Maiden Sumame, baker , City or Town, S i amsport 20c. Location - C Williams	USA - American Indian, , White, etc. White iness/Industry Home
68760,	ificate be executed by Medical Examines and business the purial-transit	edical Examiner	23a Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any leading to mead to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):	er the mode of dy	_	ac or respiratory arm	est,	Approximate Interval Between Onset and Death
P.O. Box	he death certific / the attending p ched for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3□	Ectopic pregnand Other (specify)	ey		23d. Date Mont	<i>o</i> f delivery h Day Year
Records, P.	Attending Physician: The law requires that the death certificate be executed rideath. actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Ph	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause g	ven in Part I.	1 ☐ Ye 24a. Was al autops perforn	n 24b. Wr	oute to the cause of death? Probably 4 Unknown ere autopsy findings available or to completion of cause of ath?
Vital	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:		0:	hor	eath (Check only on		Yes 2□ No
Division of	Attending Physic death. Actor: After this by the funeral dis	ation: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	4 Li Nursing	Home 5 Reside 28d. Describe ho	nce 6 ⊡Other w inju r y <i>o</i> ccurred	
DIX		Certification:	3 Suicide 6 Could not l	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (St. City or Town		or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one) 1 ☐ Certifying P 2 ☐ Medicel Exe	hysicien: To the best of my knominer: On the basis of examinat and manner stated	wledge, death tion and/or inv	vestigation, in my	ime, date and place opinion, death occurse number	curred at the time, da	ate and place, an	mer as stated. Id due to the cause(s) (Month, Day, Year)
5	H-4		30. Name and a rivess of person who	completed cause of deat		1.00	lendle	Rd 1	Willow	sout NO 21797
Ĭ	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 2	32. Registrar's Signat	ture	dones!		T Second		1

Registrar DHMH 17 Rev 1/2001 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar Amend#31,s		-		artment of F rtificate of		Mental I		ne . No. 2 (ากล	2496
		1. Decedent's Name (First, Midd		JO, D'M, ML	0			2. Date of				3. Time of Death
Physici		Cyril Samuel H	embrom					July	17	Day 2008	Year	8:00 A ^M
/Medi Examir		4a. Facility Name (If not institution		ımber)		4b. City, Town, o	r Location of Deatl	_	1/9	4c. Count	y of Death	0:00 A
		Heartland Healtl	care of Ade	lphi		A	delphi			Pr	ince Ge	eorge's
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of	Birth Day, Y	ear)	9. Birthp	place (State or Foreign
Director		220-08-4237	1 X M 2 □ F	75	Yrs.	World Days	Tiours IVIIII.	Decembe	-			India
D >		Usual Residence of Decedent 10a. State 10b. County		10a Cit	, Town or Lo	ootion						0d. Inside City Limits
aryla shor	5			100. 010	, town of Lo						'	1 ☐ Yes 2 No
the M	Director	Maryland Prine 10e. Street and Number	ce George's			10f, Zip Code	Hyattsvill	e	100	. Citizen of	What Cour	
a or						101. Zip code	20702		log	. Citizen of	U.S.	
IN LIZIS-UUSO filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Eventiner must be notified at	Funeral	8522 14th Ave		edent Ever in U.S	3 13 1	Was Decedent of H	20783	necify Yes o	No-	14 Ra	ce - Americ	
iter d	Fun	11. Marital Status 1 □ Never Married 2 🗷 Mar	Armed Fo	orces?	J. 13. 1	f Yes, specify Cuba	an, Mexican, Puerl	o Rican, etc.	140		ck, White,	
urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G	ive		1 □Yes 2 No	Specify:			Specia	fy:	Asian
A I A I S-00-30 d within 72 hours aft giene. er than "natural", or the Medical Everni	Completed		it's Education			dent's Usual Occup			16	b. Kind of E	Business/Inc	dustry
Pin 7.	ple	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	(Give life. L	kind of work done DO NOT use retired	during most of wor d)	rking				
d with	Ę,	Elementary/occordary (o 12)	2			Prin	ter			P	rivate	Industry
othe vent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nar	ne (First, Mic	ldle, Ma	iden Sumai	me)	
gas 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Ilm Medical Experimentations to notified at	ToE	Simo	n Samuel Hen	brom				Priso	illa	Maran	di	
s ma		19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Nu	mber, C	City or Town	, State, Zip	Code)
1 and 2 Health a		Pradeep Hembro	om - Son		852	2 14th Ave	nue, Hyatt	sville,	Mary	land 2	0783	
rmit. Pages 1 ar apartment of Hea portant: If item y injury or other		20a. Method of Disposition	• C	A 0	lace of Dispo	sition (Name of natory or other place	ce)	Date	20	c. Location	- City or To	wn, State
permit. Pages: Department of important: If ite any injury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State		ington Cem	i i	/18/2008		Ade1	ohi, Ma	ryland
partn porta		21. Signature of Funeral Service	Licenses	+	. 22	. Name and Addre	ss of Facility					
88 = 88		Nonca A	· Namas	~		ines-Rinald 1800 New Ha	ı Funeral mpshire Av	enue, I	ıc. ilver	Sprin	g, Mary	yland 20904
		23a. Part 1. Enter the disease, o shock, or heart fall re. Lis	r complications that	caused the death			*					Approximate Interval Between
Physician		Immediate C (Final disease or condition		ocardial	Inforet	ion					- H	Onset and Death 5 minutes
/Medical		resulting in death)	- a.	(or as a consequ		LOII) mindles
Examiner			Pe	ripheral	Vascula	r Disease					,	Years
71 +	ē	Sequentially list conditions,	D	or as a conse i								
ficate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	c. <u>Diabetes Mellitus</u> Years							Years		
e exe		resulting in death) Last	Due to	(or as a consequ	ence of):							
icate be ex physician at the burial-	dical		d									
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he death certifing the attending I	Physician/Me	23b. Was decedent pregnant		tcome of pregna birth 2 Petal		Ectopic pregnanc	v			1.1	ate of delive	
	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of d		Other (specify) _	,		_	M	onth	Day Year
at the de by the	J.	9 ☐ Unknown										
res that signed I	b	Part II. Other significant conditi	ons contributing to d	leath but not resu	ılting in the ur	nderlying cause giv	en in Part I.					he cause of death?
w require s been signal	ted	Decubitus				-		1	☐ Yes	2 □ No	3∐ Prot	oably 4 🛣 Unknown
The law requires the has been signed age 2 should be d	Completed	Hypertension						24a. V	Vas an utopsy	24b.	Were auto	psy findings available
sician: The la certificate ha irector, page 3	mo;								erforme	d?	death?	•
hysician: nis certifica director, p	Be C	25. Was case referred to medica examiner?	1				26. Place of Dea			2.10		
nysic direc	70 E	1 Yes 2 X No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 🗷 Nursing H	lome 5 ☐ F	Residenc	ce 6 □Ot	her (Specil	(y)
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ath. Pr: Ai	atic	2 ☐ Accident invest	M A D A C D									
I or Attending Physician: Taffer death. Director: After this certificat d in by the funeral director, pa	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be nined 28e. Place build	e of Injury - At ho	me, farm, str	eet, factory, office			n (Stree		ber or Rura	al Route Number,
ital o	Certification:											
lospi hou uner uner			ng Physician: To the Examiner: On the I									
To the Hospital or Attending Physician: The law requires that the within 24 hours after death of the Thores after death of the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	one)	and mar	ner stated.								
o time	Σ	29b. Signature and title of certific	1 1			29c. Licens	e number		29d	. Date sign	ed (Month,	Day, Year)
5		1 70	li			101	7607		1	1.6	-0	Ö
, -		30. Name and address of person	who completed cau	se of death (Item	23a) (Type,	Print)	1	0	A			Cather N
		Juli Ko	man	109	510	Darn	25 to wo	n K	1 8	e 2	07	Cather N
Sta	ite	31. Date filed (Month, Day, Year,	32.	Registrar's Signa	ture	1					ľ	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 1:35 AM L. Catherine Hastings 0 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisbur Hospice at the If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/23/1920 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 👿 F 578-26-2707 87 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Exa<u>miner must be notified at</u> 1 ☐ Yes 2 X No Director MD Worcester Whaleyville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 9036 Peerless Rd. 21872 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white Completed by 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 1 and 2 should be filed wi Health and Mental Hygien Im 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lola Thompson Joseph M. Carpenter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health ar
Important: If Item 27 is n Jean Jerread / daughter 9036 Peerless Rd., Whaleyville, MD 21872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Cape Henlopen Crem. 7/21/2008 Frankford, DE 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, MD 21811 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, call only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure Immediate Cause (First disease or condition resulting in death) METASTATIC CARCINDINA **Physician** OSSIBLY /Medical Due to (or as a consequence of): **Examiner** DESTRUCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transi Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 2 Ro 3 Probably 4 Unknown Be Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2□No autopsy Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1- Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) and manner stated.

BA 10

State Registrar

31. Date filed (Month, Day, Year) 2 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

GHUMAN WARY

29c. License number

10058410

PODOX 1733 SAUSBURY UD

29d. Date signed (Month, Day, Year)

						artment of Health		_	oie.		
		,	1 - State Registrar	iale of Maryland	•	rtificate of Deat		Reg. No. 2	08 21.063		
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Richard H	firschaue			2. Date of D Month July	eath Day	Year 0330 A M		
	Examir	ner	4a. Facility Name (If not institution, give stree	I AI I O	i l	4b. City, Town, or Locatio	n of Death	4c. County	of Death		
100	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	cute ast birthday)		er 24 Hrs. 8. Date of B	irth Day, Year)	Birthplace (State or Foreign		
	Director		215-56-7983 IMM	^{2□ F} 55	Yrs.	Months Days Hours	Min. (Month, D	R 5, 1952	MARYLAND		
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	ocation			10d. Inside City Limits		
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Exzminer must be notified at	Director	MARYLAND QUEEN AND 10e. Street and Number	NE S	CENTR	EVILLE		40a Citiaan af M	1 □ Yes 2 No		
	3a or		201 DUDLEY COURT			10f. Zip Code 21617		10g. Citizen of W	D STATES		
	death	Funeral	11 Marital Status 12. V	Vas Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of Hispanic (If Yes, specify Cuban, Mexic	Origin? (Specify Yes or N		e - American Indian, k, White, etc.		
36	72 hours after death w 'natural', or items 23a dical Examiner must t	by Fu	1 Never Married 2 Married 1	∏Yes 2 XNo fYes, Give fear or Dates:	- 1	1 □Yes 2 XNo Speci			WHITE		
21215-0036	72 hou natura	eted I	15. Decedent's Educatio (Specify only highest grade cor	n	16a. Dece	dent's Usual Occupation	ant of working	16b. Kind of Bu	siness/Industry		
121	within 72 ho piene. r than "natur r to Vedical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done during m DO NOT use retired)	ost or working	DEAT	rom Amr		
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ılan	Q # D 9	To Be	RUSSELL HIRSCHAUE	R		į I	ILY KENNY				
Maryland	and s m	ľ	19a. Informant's Name/Relationship (Type. F	· · ·		ng Address (Street and Nun					
e, 1	1 and Healt em 2 ther	1 2	LYNN HIRSCHAUER/WIF			DUDLEY COURT	Date Date		AND 21617 City or Town, State		
mo	ē ± ÷ ē		1 ☐ Burial 2 【**Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	varirom State		osition (Name of matory or other place) CE CREMATION	JULY 21 2008		ILLE, MARYLAND		
Baltimore,	permit. Pa Departmen Important: any injury once.		21. Signature of Euneral Sovice License						ERAL HOME, P.A.		
_	<u>205</u>	10 . !!	(are	780	110	06 SHAMROCK R ter the mode of dying, such	OAD, CHESTE	R, MARYLA	ND 21619 Approximate		
	Physician /Medical Examiner parial-transit	Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	erice of).	Soft tiss	ne infec	pm	Inferval Between Onset and Death		
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Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospi	tal:		Other:	ce of Death (Check only				
of	ding Phys h. After this funeral di	n: To	27. Manper of Death		28b. Time o	f 28c. Injury at	Nursing Home 5 Res	sidence 6 Other			
Division of	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	1 Natural 5	(Month, Day, Year) Be. Place of Injury - At hon building, etc. (Specify,	Injury ne, farm, str	Work? 1 □Yes 2	28f. Location	Location (Street and Number or Rural Route Number, City or Town, State)			
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	the Ho hin 24 the Fu	Medical	one)	and manner stated.	on and/or ir	ovestigation, in my opinion, o					
	7 with	-	29b. Signature and title of pertifier	1		29c. License numbe		_	(Month, Day, Year)		
			30. Name and address of person who comple	eted cause of death (Item	23a) (Type,	Print)	رحر ل	- my	CI , 6008		
			Jay Mengher	22	Son	the Green	e Street	Balk, M	21,200B UD 2161		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure	Aprile .		•			

DEDI A FORMATION State of Maryland / Department of Health and Mental Hygiene

ILL		Registral Registral		Ce	rtificate of	Death		Reg. N	。 2008 2	24964	
Physici	ian	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Yea							ay Year	3. Time of Death	
/Medi		Beatrice Kalfas	Hanft		T		July	÷	2008	10:58 a	
Exami	ner	4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Dea	ath	4	c. County of Death	h	
		4521 East West Hi			Bethe If Under 1 Year		S O Data of D		Montgome		
Funeral Director		5. Social Security Number 6. Sex	M 257F	s. last birthday) Yrs.	Months Days	Hours Mir	n. (Month, D			hplace (State or Foreign untry)	
		Usual Residence of Decedent	9	0 ''s.			Jan. 19	9, I	918 Ne	w York	
/land		10a. State 10b. County	10c. C	City, Town or Lo	ocation					10d. Inside City Limits	
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or 282	Directo	10e. Street and Number	<u> </u>	<u> </u>	10f. Zip Code	··· ·		10g. C	10g. Citizen of What Country?		
23a c		4521 East West H	ighway, Apt.	712	2	0814		U	SA		
SWB	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin?	Specify Yes or N	0-	14. Race - Amer Black, White		
ntal Hygiene. doother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 □Yes 21⁄2 No		,		Specify: Whi		
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d other event, t	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle		n Surname)		
n and Mental Is marked o raumatic eve	ြို	James Kalfas					Mavrogia				
of Health and Mer Item 27 Is marke other traumatic		19a, Informant's Name/Relationship (Ty		19b. Maili	ng Address (Stree	t and Number or I	Rural Route Num	ber, City	or Town, State, Z	(ip Code)	
em 27		Cheryl H. Harvey/ 20a. Method of Disposition			Lakeview		, Locust		ove, VA Location - City or		
		NEXBuria 2 ☐ Cremation 3 ☐ R			osition (Name of matory or other pla leaven Ce		July 23	200.	Location - Oity or	Town, State	
ntant njury		4 □ Donation 5 □ Other (Specify) 21. Sign sturn of Funeral Service Licen					2008			ing, Marylar	
Department Important: If any Injury or once,		21. Signatur of Funetal Service (Certa	Looma	/	2. Name and Addr rancis J						
		23a. Part 1. Enter the disease, or compli	cations that caused the dea		00 Unive				ver Spri	Approximate	
		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.		,	3,	,	,	-	Interval Between Onset and Death	
sician edical		disease or condition resulting in death)	Lung Cance Due to (or as a conse							4 Months	
miner			Atmin Fib		000						
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse		OII						
ndransit	Examiner	Cause. Enter Unidenying Cause (Disease or injury that initiated events	Coronary A	rtery D	isease						
an ar rrial-t		resulting in death) Last	Due to (or as a conse	equence of):							
hysic he bu	ical	C	1								
iding physician and se as the burial-transit	/Medical	IF FEMALE:									
attend for use		23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3	Ectopic pregnan	су			23d. Date of deli Month	ivery Day Year	
the a	sic	1 □Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	f death 5[Other (specify)				World	Day 10a.	
been signed by the should be detached	Physiciar	Part II. Other significant conditions cor	ntributing to death but not re	esulting in the u	nderlving cause gi	ven in Part I.	23e, Did	tobacco	use contribute to	the cause of death?	
signed be	l by			g						obably 4 🗆 Unknown	
peen	Completed						-				
201	mp							s an opsy formed?	prior to death?	topsy findings available completion of cause of	
ficate r, pag		05.114					1 □ Yes	2 🙀		2 □ No	
iis certificate ha director, page 2	Be	25. Was case referred to medical examiner?	lospital:		Ot		eath (Check only				
this ald	P	1 ☐ Yes 2 ☐ No F	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	28b. Time o	III 3 LI DOA	4 🗀 Nursing	Home 5k Res		6 ☐ Other (Spec	cify)	
After funer	ţi	1 🛣 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	Wo	rḱ?]Yes 2. □No		,	,		
Director: I in by the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, str						ıral Route Number,	
I Direct	Certification: To	4 ☐ Homicide determined	building, etc. (Spec	cify)			City or To	wn, Sta	te)		
To the Funeral Directo	Medical C		sician: To the best of my kiner: On the basis of examinand manner stated.								
To th	Me	29b. Signature and the of certifier	111			se number		29d. D	ate signed (Month	h, Day, Year)	
		avel losos	Capes,	ws		D57304		Au	gust 14,	2008	
		30. Name and address of person who co		em 23a) (Type.	Print)						
		Eirene Koroulaki			ticut Av	enue, Ke	nsington	, M	D 20895		

State Registrar 31. Date filed (Months Payp Year) 2 2008 32. Flaistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Suzie Mae Johnson July 18, 2008 1:50 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arcola Health & Rehab. Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🙀 F **Director** 577-48-0148 Virginia 74 June 25, 1934 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tems 23a or 28a-f show er must be rotified at 1 ☐Yes 2 🙀 No Director Maryland Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5024 Adrian Street 20853 USA. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ٥ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: 3 ☐Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, Its once. Head Cook US Department of Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Edmonds Mamie Eldrid Moore ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn E. Johnson/Daughter 1957 Rosemary Hills Drive, #3, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State July 20, Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signatur of Funeral Service Licensee 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one car ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** Multiple Myeloma 6 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy 2 🖪 No 2 🗆 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: AL Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1X Natural 5 ☐ Pending investigation spital or Attendl nours after death. neral Director: A death. 1 ☐ Yes 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records,

within 24 hours

Registrar DHMH 17 Rev 1/2001 29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, I

Barry Rosenbaum, MD

Day Year)

Medical

State

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3720 Farragut Avenue, Kensington, MD 20895

29c. License number

D09834

29d. Date signed (Month, Day, Year)

July 18, 2008

			For	State of Marylan	d / Depa	artment	of Health and	•	ygiene			
			1 - State Registrar		Ce	rtificate	of Death			08 24966		
	Physici	an	Decedent's Name (First, Middle, Las	,				2. Date of D Month	Day	3. Time of Death		
	/Medic					45 Ch. T	4b. City, Town, or Location of Death			2008 3:06 P M		
	Examir	ier	Prince George's				ver1y	n	4c. County			
-	Funeral		5. Social Security Number 6. So	· · · · · · · · · · · · · · · · · · ·	last birthday)	If Under 1	Year If Under 24 Hrs	8. Date of B	irth	9. Birthplace (State or Foreign		
	Director		218-90-7291	□ ^{M 2}	Yrs.	Months	Days Hours Min.	8 12	ay, Year) 1964	Washington, DC		
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c Cib	y, Town or Lo	nation						
	Maryla f • ho	ō								10d. Inside City Limits 1 Yes 2 No		
	188 In 188	Director	MD Prince Ge	orge's N	ew Car	10f. Zip (10g. Citizen of N			
2	d within 72 hours after deeth with the Maryland ylane. Than "naturel", or iteme 23a or 28e-f ehow the Madical Examiner must be notified at	Ö	7600 Fontaine Blo	eu Drive Ant 3	10		20784		10g. Citizen of What Country? USA			
	deet	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?			nt of Hispanic Origin? (S y Cuban, Mexican, Puer	pecify Yes or N		e - American Indian,		
9	or its	교	1 Never Married 2 ☐ Married	1 ☐ Yes 2X No		iires, specii 1 ∐ Yes 2∛i		o rican, etc.)	Specif	ck, White, etc. v: Black		
ë ,	ure!'.	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:								
5	"nat	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece (Give	dent's Usual kind of work	Occupation done during most of wo retired)	rking	16b. Kind of B	usiness/Industry		
212	within iene. r than "	E	Elementary/Secondary (0-12)	College (1-4or 5+)					Hote1	Industry		
פ	other	0	17. Father's Name (First, Middle, Last)		EIIV	TEOIME	ntal Specia 18. Mother's Nam		e, Maiden Suman			
Maryland 21215-0036	should be nd Mental marked o umatic eve	ToB	Unknown				Robin	Marie J	ones			
<u>a</u>	2 8 8 5		19a. Informant's Name/Relationship (7							State, Zip Code) 20784		
<u>ر</u> در	and lealth m 27		Robin Marie Jone						-	Carollton, MD		
Baltimore,	Pages 1 nent of H ant: if ite ary or of		20a. Method of Disposition 1	Removal from State	lace of Dispo emetery, crei	natory or oth	er place)	Date	20c. Location -	City or Town, State		
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Ba	permit. Pag Dapartment important: i eny injury o		Mana Mana	Charten			Address of Facility Ft adensburg R					
			23a. Part1. Enter the disease, or comp	plications that caused the death						Approximate		
F	hysician		shock, or heart failure. List only of Immediate Cause (Final		1.					Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)	a Septic Shoo								
	Examiner		Sequentially list conditions	U.T.I.								
	sit 9d	iner	Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury	Due to (or as a consaqu	lianne of):							
	be executed icien end burial-transit	Examine	that initiated events resulting in death) Last	cDue to (or as a consequ	ience of):							
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68/	leath certificate attending phys I for use as the	edic		d								
Box	death certifica e attending phy id for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		-			23d. Da	te of delivery		
	0 0 9	sicia	in the past 12 months? 1 ☐ Yes 2 🖾 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pred Other (spec			Mo	onth Day Year		
о. О	d by the	Phy	9 Unknown					7				
Ś.	ine law requires that the or ste hes been signed by the page 2 should be detached	δ	Part II. Other significant conditions co	untributing to death but not resu	ulting in the u	nderlying cat	ise given in Part I.		_	ribute to the cause of death?		
0	need	etec						1 <u>-</u>	Yes 2∏ No	3 Probably 4 Unknown		
Vital Record	hes hes	Completed							ppsy	Were autopsy findings available prior to completion of cause of death?		
		ပိ	25. Was case referred to medical					1 Yes	2 No	1 Yes 2 No		
>	Attending Proysician: r death. sctor: After this certific by the funeral director,	0 B	examiner?	Hospital:	EB/Outpatier	nt 3 DOA	Other: A D Nursing b		one/ sidence 6 □Oth			
ס ל	g Pn terthi	T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	-	: Injury at Work?		how injury occur			
Ď.	endin path. or: Afr	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	М	Work? 1 ☐ Yes 2 ☐ No					
Division	or All offer de Direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory,	office		(Street and Numb own, State)	er or Rural Route Number,		
ַ ב	nospital (4 hours et Funerel D tely filled it			1								
	Prospital 24 hours e Funerei I etety filled	edicai	29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exam	ysician: To the best of my know niner: On the basis of examinat and manner stated.	wledge, deatl tion and/or in	n occurred at vestigation, i	the time, date and place my opinion, death occu	, and due to the rred at the time	e cause(s) and ma , date and place,	anner as stated. and due to the cause(s)		
	To the hospital or Attending Prysician; within 24 hours after death. To the Fundrel Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifier			29c.	License number		29d. Date signe	d (Month, Day, Year)		
ĺ	(2)		> alun a	2)		7	27,577		7/16	105		
	SIE .		30. Name d address of person who d	como led cause of death (Item	23а) (Туре,	Prit)	1/3//					
	ے ہور		Ophnell Cumberbat			Drive,	Cheverly,	MD 2078	5			
	Sta Registr		JUL 2 2 2008	32. Registrar's Signat	ture	1						
	riegisti	uı	332									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:30 AM Chant **Physician** JULY lana /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If no institution, give street and number) Examiner Baltimore Vear | If Under Hospital Agnes 8. Date of Birth (Month, Day, Year) March 31, Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 5. Social Security Num . Age (In yrs. last birthday) **Funeral** Min. Months Days Hours Yrs. 1951 Burma 213-96-3059 57 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 'natural", or items 23a or 28a-f shov dieal Evanting must be notified at 1 ☐ Yes 2 XNo Funeral Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 4710 Aldgate Green 21227 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Asian 1 ☐ Yes 2 K No Baltimore, Maryland 21215-0036 Specify ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 7 Is marked other than traumatic event, the Me Elementary/Secondary (0-12) College Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kim Kuei Tan Sho Chein Kan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chu Hwa Chen Kan/Wife 4710 Aldgate Green, Baltimore, MD 21227 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition July 20 Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2008 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee MD 20901 500 University Blvd, W, Silver Spring, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a cause on each line. Immediate Cause (Final disease or condition resulting in death) Hours Physician Brain Death /Medical Due to (or as a consequence of): Intraventricular hemorrare **Examiner** alarachnoil Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an this certificate has autopsy performe 1 □Yes 21 No Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

2 1 2008 Registrar

31. Date filed (Month, Day, Year)

isbeth N.l

lovet 32 Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900S. Caton

P20556

Ave Baltimore, MD 21229

ウスター

State of Maryland / Department of Health and Mental Hygiene 24968 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2008 ам July 18, Margaret Louise Keller 9:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Montgomery Rockville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | Feb. | 8, 5. Social Security Number 9. Birthplace (State or Foreign Country)

New York 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 F Months 054-18-4388 83 Feb. Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show ral", or items 23a or 28a-f shov Examinar must be notified at Director 1 ☐ Yes 2 No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4544 Minuteman Drive 20853 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 25 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify. þ 3 ☐ Widowed 4 ☐ Divorced 'natural" Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and 2 should be filed within 'lealth and Mental Hygiene.'m 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant Computer Systems 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Tump Louise Taffner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert F. Keller/ Son of Health 4544 Minuteman Drive, Rockville, MD 20853 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If iter
any injury or oth Date 20c. Location - City or Town, State July 2008 18 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of):
Cerebrovascular Accident Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and the burial-trai Due to (or as a consequence of) led by the attending physician detached for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) I ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 2X No 1 ☐ Yes Director: After this certification by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospice Hospital: 1 ∐Yes 2 ∐XNo 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca (Check o one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier levere D64615 July 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, MD 20855 Gemevieve Wroblewski, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 21 2008

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

		_ For	State of	Marylan	d / Depa	artment of H	lealth and	Mental Hy	giene		
		1 - State Registrar			Ce	rtificate of	Death		Reg. No.	2008	3 24969
Physicia	an	Decedent's Name (First, Middle,	Last)					2. Date of De Month	ath Day	Year	3. Time of Death
/Medic	al	JOS		KUHA	RIK	1 44 60 7	1	JULY			
Examin	er	4a. Facility Name (If not institution,			III D	,	r Location of Dea	ath		County of Deat	
Funeral		PRINCE GEORGE 5. Social Security Number		AL CENT 7. Age (In yrs.		If Under 1 Year	EVERLY If Under 24 Hr	s. 8. Date of Bir	th	9. Birt	GEORGE State or Foreign
Director		211-10-4508	1 ∑ M 2□F	91	Yrs.	Months Days	Hours Mir	n. (Month, Da JAN . 2			PA.
pu *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	neation					10d. Inside City Limits
/aryla	ō		GEORGE'S	7001011	y, rom o. 2.		OT T TON				1 ▼ Yes 2 □ No
with the Maryland a or 28a-f show t be notified at	Director	10e. Street and Number	GEORGE 5			NEW CARR	OLLION		10g. Citiz	en of What Co	ountry?
th with		8203 LEGATI	ON RD.				20784			U.S.A.	
after death with the Maryland or Items 23a or 28a-f show miner must be notified at	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.	S. 13.	Was Decedent of I If Yes, specify Cub		(Specify Yes or No	. 1	4. Race - Ame Black, Whit	erican Indian,
s after	by Fu	1 Never Married 2 Marrie	ed 17 Yes	2 No		1 ☐ Yes 2 No	Specify:	,		Specify:	
hour tural' al Ex		3 ☐ Widowed 4 ☐ Divorced 15. Decedent'		ites: WWII		dent's Usual Occup	nation		16h Kin	WH. d of Business/	HITE
in 72 n "na Aedic	plet	(Specify only highes: Elementary/Secondary (0-12)	t grade completed)	4005.)	(Give	kind of work done DO NOT use retire	during most of w	rorking	100. Kill	a or Business/	moustry
d with giene er tha the l	Completed	12	College (1-	-401 5+)		SALESM	AN		L A	AUTOMOT	TIVE
be file tal Hy d othe	Be (17. Father's Name (First, Middle, L	.ast)				18. Mother's Na	ame (First, Middle	Maiden S	Surname)	
ould by Meni	우	MICHAEL		KUHARI	7			JULIA		HAKAN	
12 sh h and 7 is m traum		19a. Informant's Name/Relationsh		-		ng Address (Street					
1 and Healt em 2		BERNADINE B. KU	HARIK/WIFI	20b. F	lace of Dispo	B LEGATIO position (Name of		NEW CARRO		N, MD.	
ages ent of t: If it y or o		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (Sp		state		matory or other pla	· i			•	,
permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must one.		21. Signature of Funeral Service I,		CH		CREMATO 2. Name and Addre		9-2008		ERDALE,	
Per Imp any		121/11/Ch	anlune	70 моо	091	2. Name and Addre CHAMBERS 5801 CLEV	FUNERAL ELAND AV	HOME & C E., RIVE	REMA' RDALI	CORIUM, E. MD.	P.A. 20737
V		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that ca	used the deat							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	GASTI	ROINTES	TINAL	BLEEDING					Onset and Death 2 DAYS
/Medical Examiner		resulting in death)		or as a conseq	uence of):						
	7	Sequentially list conditions,	b. SEPSI	IS V ms a nonseq	uence offi						3 DAYS
uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1 1 1 2 2 2 7 2								
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cate be executed physician and the burial-transit	dical	1	d						_		
ertifica ling pl e as t	0	IF FEMALE:									
leath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?		ome propregna irth 2□Feta ant at time of d	Ideath 3[□Ectopic pregnanc □ Other (specify) _	у		23	3d. Date of del Month	livery Day Year
the d	ıysid	1 Yes 2 No 9 Unknown	9□Unkno		eatii J						
The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	by Ph	Part II. Other significant conditio	ns contributing to de	ath but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did 1	obacco us	e contribute to	the cause of death?
aquire en sig	q pa	STROKE, COLON	CANCER, A	ATRIAL	FIBRII	LATION		_ 1_	Yes 2□] No 3 🗆 Pr	robably 4XIUnknown
law re as bee 2 sho	Completed							24a. Was		24b. Were at	utopsy findings available
	E OC								ormed?	death?	completion of cause of 2 □ No
slcian: The certificate t rector, page	Be (25. Was case referred to medical examiner?	11			Law		eath Check onl	^		
Physical this cal dire	10	1 Yes 2 No	Hospital: 1 XIn		ER/Outpatie	IL SELDOX		Home 5 ☐ Resi			ecify)
ding	ion	27. Manner of Death 1 Natural 5 Pending 2 Accident investig	(Month	h, Day Year)	28b. Time o Injury	Wo	ryat rk? Yes 2∐No	28d. Describe	now injury	occurred	
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al or after it Direction bid in b	Certification:	4 ☐ Homicide determine	buildin	ng, etc. (Specif	y)			City or To			,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 XCertifying	Physician: To the Examiner: On the ba	best of my kno	wledge, deat	th occurred at the ti	me, date and pla	ice, and due to the	cause(s)	and manner as	s stated.
the H nin 24 the F nplete	Medical	one)	and mann	er stated.	7			correct at the time,			
5 t y S	2	1 / tayon / DODE 8212 7/18/									th, Day, Year)
241		-tarkey	1	of death (14	20=) /7:		0,0		1/	10	10
		30. Name and address of person v FARHAD JAMA	who completed cause LI, M.D.			WAY CENT	ER DR	GREENREI.	т. мг). 2077	0
Sta	te	31. Date filed (Month, Day, Year)	39. Re	egistrar's Signa		OLIVE.		3	_, 111	2011	-
Registr	ar	.111 2.1 2	008	was H	100	affi I					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 LINDA DOREEN KENDALL JULY 18 3:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner. **OUEEN ANNE'S** 606 GRANNY BRANCH ROAD CHURCH HILL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral 6 Sex 7. Age (In vrs. last birthday Days Hours 1 ☐ M 2 😿 F MARYLAND Director 214-70-5331 52 FEB. 18, 1956 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND QUEEN ANNE'S CHURCH HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 606 GRANNY BRANCH ROAD 21623 UNITED STATES Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS FOOD SERVICE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (VERA MAE WHITE JACK KENDALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SHANNA MAE KENDALL/DAUGHTER 14600 CHERRY LANE, RIDGELY, MARYLAND 21660 20b. Place of Disposition (Name of CHESAPEAKE CREMATION CENTER 7-21-2008 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) STEVENSVILLE, MD 21. Signatuk / Funeral Service 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 SOUTH LIBERTY STREET, CENTREVILLE, MD 21617 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastaho vears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any list in the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknow þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by e e No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 certificate has autopsy performed? Yes 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident the 1 after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 X Certifying Physician: To he est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) Medical Examiner: asis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) nner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D66276 30. Name and address of person who completed cause of death (Item 2001 Type, Print) Easton, MD 21601 8221 MD Halverson 31. Date filed (Month, Day, Year) State 2 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 24971 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day 7:30 a MAudrev Mae July 15, 2008 Keller /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 XF 579-20-2149 D.C. Director 85 26, 1922 Dec. Usual Residence of Decedent death with the Maryland ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 234 Dale Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White þ 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State Department permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, Item Mo College (1-4or 5+) Elementary/Secondary (0-12) Office of Personnel Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maynard D. Ouick Bertha V. Loveless 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Ann Keller/Daughter 11816 Breton Court, #22, Reston, VA 20191 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ♣ Byrra 2 □ Cremation 3 □ Removal from State July 25, Arlington National Arlington, Virginia 4 Donation 5 Dother (Specify) 2008 Cemetery 2000

22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. of Punaral Salvind gnatu 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure 2 weeks /Medical Due to (or as a consequence of): Examiner Non-Small Cell Lung Cancer 6 Months Sequentially list conditions, Examiner One to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year signed by the a 1 ☐Yes 2 ☐ No o 9 Unknown 9 Unknown <u>۵</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed' certificate 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No this 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of centifier 29d. Date signed (Month, Day, Year) August 15, 2008 D35996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Linda M. Burrell 2730 University Blvd., #400, Wheaton, MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

1. Decedent's Name (First, Middle, Last)

1 - For State Registrar

Physician

	Physici /Medic		Catherine Amelia LYNN		Month .7		21 255 7.55		7.55 AM	
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	Location of Death		4c. County of Death		
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	Funeral Director		214-09-6639 1□M 2XF	vrs. last birthday) Yrs.	If Under 1 Year Months Days		Date of Birt (Month, Da) Jan。 4	h y, Yea <i>r</i>) 1919	Cour	olace (State or Foreigntry) yland
	and w		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	cation				1	Od. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If it iem 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Eventral profilled at	by Funeral Director	Maryland Washington 10e. Street and Number	Hager	stown 10f. Zip Code			1 √ Yes 2 □ No		
	with Sa or	Ö	312 E. Irvin Avenue			742			JSA	,.
	death	nera	11. Marital Status 12. Was Decedent Ever in	1 U.S. 13. \		/ 42 lispanic Origin? (Spec an, Mexican, Puerto Ri	fy Yes or No-		e - Americ	can Indian,
21215-0036	urs after al", or Ite	by Fu	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes Give Year or Dates:		If Yes, specify Cuba 1 □ Yes 2 🗓 No	Specify:	can, etc.)	Specify	k, White, Wh	^{etc.} nite
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Ġ,	1 and 2 Health cem 27 i	1.13	Suzanne Lynn - Daughter 20a. Method of Disposition 20		sition (Name of natory or other place	d Road, Win		20c. Location -		
ПÖ	Pages Thent of Hant: If ite		10 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			i	,,,,			
Baltimore,	ヨモモラ .		21. Signature of Funeral Service Licensee		ill Ceme : 2. Name and Addre			Hagersto Funeral		Maryland
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	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a constitution)	ncerti		ng, such as cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
68760,	the attending physician and the attending physician and the attending physician and the for use as the burial-transit	dical Examiner	Esquentially list co-driens, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a constitution of the constitution of		cry c	votery	di	Pase		
O. Box	the death certif by the attending ached for use as	nysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	☐ Ectopic pregnand ☐ Other (specify) _	у		23d. Dat Mo	te of deliv	ery Day Year
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Divi	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Sp	t home, farm, str e <i>cify)</i>	eet, factory, office		f. Location (8 City or Tov	Street and Numb vn, State)	er or Run	al Route Number,
	the Hosp in 24 hou the Fune ipletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examand manner stated.	knowledge, deat nination and/or in	th occurred at the ti	me, date and place, as opinion, death occurred	d at the time,	date and place,	and due t	to the cause(s)
	Vit To	Σ	29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed	1 (Month,	Day, Year)
			Mana Jahmos		Door	3233		07/2	21/2	808
,	11		30. Name and address of person who completed cause of death (*					
1	4-10		SHAHIS MAHMES MD SECNOR		AUE SUIT	EC HAGI	ERSTOW	am mo	217	42
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Si JUL 2 2 2008	gnature	1					
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DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1930 P M Mary Ruth Lively Ju1y 24 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Manor Healthcare Center Cecil Kising Sun 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 Months Days Hours SEPT 5, Director 215-16-9590 87 1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Maryland Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2 any hijury or other traumatic event, the Medical Examiner must be no once. 89 Sylmar Road 21911 United States by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Garment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George R. Chapman Lettie R. Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel S. Ward/Son 78 Van Weaver Drive, North East, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor
Memorial Park July 30 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Elkton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Approximate Interval Between Onset and Death 2-3 dup 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Infection of Underermined Origin **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Cardiomy spathy 1 ☐ Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 1 Natural 2 Accident 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: A 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a **To the Funeral I**completely filled 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

DHMH 17 Rev 1/2001

MO

Sun

215179 Sn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Way

2008

COLONIAL

AUG - 4

31. Date filed (Month, Day, Year)

D0058354

21911

DEIL E. LATTIN, M.D.

			For	State of Ma	-	partment of				2000	01075
			Registrar 1. Decedent's Name (First, Middle, La	ast)		ertificate of	Death		Reg. of Death	No. 2008	3. Time of Death
	Physicia		James D. L					Jul		Day Year	12:30P M
-	/Medic Examin		4a. Facility Name (If not institution, gi			4b. City, Town,	or Location		, 23	4c. County of Dea	
-			6002 Maria Ave	nue		Suit				Prince	Georges
	Funeral		Social Security Number 6.		(In yrs. last birtho	Months Days		Min. (Mor	of Birth oth, Day, Ye	ar) Co	thplace (State or Foreign puntry)
	Director	ŀ	585-02-0899 Usual Residence of Decedent		46			Mar	ch 4	1962	NC
	yland yland		10a. State 10b. County		10c. City, Town o	Location					10d. Inside City Limits
	e Mar 3a-f sl	Director	Md. PG		Suitla	nd					1 ZWes 2 No
	ith th		10e. Street and Number			10f. Zip Code			10g.	Citizen of What Co	ountry?
	s 23a	eral	6002 Maria Av	12. Was Decedent Ev	or in 110	2074		rigin? (Specify Voc		United S	
' 0	fter de r item iner	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	Armed Forces?)	3. Was Decedent of If Yes, specify Cub			(c.)	Black, Whit	
036	hours after death with the Maryland tural", or items 23a or 28a-f show al Examinar must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ⊡Yes 2 ∑X No	Specify:	•		Specify:	Lack
5-0	72 na	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. D	ecedent's Usual Occu live kind of work done le. DO NOT use retire	pation during mos	st of working	16b	. Kind of Business	/Industry
121	d within giene. er than "	du	Elementary/Secondary (0-12)	College (1-4or 5+)		ed)			71	2 2
d 2	filled Hyg ther snt, 1		12 17. Father's Name (First, Middle, Las.	t)	Sa	lesman	18. Moth	er's Name (First, M		Sheehy I den Surname)	rord
an	9 g 4 2	To Be	Walter Lilly				Joy	vce Pa	rker		
Maryland 21215-0036	12 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship	(Type. Print)		ailing Address (Stree			Number, C	ity or Town, State,	Zip Code)
, N	ang sal		Joyce Jordan/	mother		02 Maria itland, M sposition (Name of crematory or other pla	$d \cdot 20$	nue 0746			
altimore,	Pages 1 and of He Int: If item		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐	Removal from State	1			071700	200	. Location - City or	Town, State
ţ	# 든 본 은 .		4 Donation 5 Other (Special	•	Riverd	ale Park				Riverda	le,Md.
Ba	permi Depa Impo any ir		21. Signature of Funeral Service Lice	Hool ar.	_	22. Name and Addr					
ł			23a. Parti. Enter the disease, or con shock, or heart failure. List only	nplications that clused t	he death. Do not	enter the mode of dy	ing, such as	HIII RO s cardiac or respira	tory arrest,	uitland	Md 20746 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	one cause on each line	no mi	207/21					Onset and Death
	/Medical		resulting in death)	a. Due to (or as a	consequence	Parny					10/1000
	Examiner	Ļ	Sequentially list conditions,	b. 141	cetens	1000					12 years
7	ted 1sit	nine	cause. Enter Underlying Cause (Disease or injury	A-16 a	rionsequence arti						2024
19.	execun and ial-trai	Examiner	that initiated events resulting in death) Last		consequence of):	0/7					12 Years
8760,	death certificate be executed e attending physician and of for use as the buriat-transit			- DIBBIA	Ties	meliTi	5				DURBAS
9	artifica ing ph as th	Physician/Medical	IF FEMALE:								-
Вох	eath certific attending p for use as	ian/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	Fetal death	3 Ectopic pregnan	су			23d. Date of de	livery Day Year
Ö	the de	ysic	1 ☐Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	time of death	5 ☐ Other (specify) _			_		,
т. С.	law requires that the das been signed by the 2 should be detached		Part II. Other significant conditions	contributing to death but	not resulting in th	e underlying cause gi	iven in Part I	I. 23e	. Did tobac	co use contribute t	the cause of death?
rds	quire; en sig	ed by	GRETHAD STALL	ruel					1 🗆 Yes	2 No 3 P	robably 4 Unknown
ecc	2 98	plet	Rence Congs.	ere				24a	. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
of Vital Records,	ate pag	Completed	OLABOR THE NEUR	00 mg				1 🗆	performed Yes 2	death?	
Vita	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ot	26. Place	e of Death (Check	only one)		
ð		5.	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury	t 2 ER/Outpa	Ment 3 1 DOA	4 🗀 🕅			e 6 ☐Other (Spenjury occurred	ecify)
on	Attending Phr r death. ector: After thi by the funeral	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day,	Year) Inju		orkí? ⊒Yes 2.⊟			.,,	
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	Hospital	Medical		hysician: To the best of miner: On the basis of	examination and/						
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Mec	29b. Signature and title of certifier	and manner state	eu.	29c. Licen	ise number		29d.	Date signed (Mon	th, Day, Year)
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		-	30. Name and address of person who	completed cause of dea	ath (Item 23a) (Ty	pe, Print)	/ (W-001 W -		7/29/s.	40
	n										
	Sta		31. Date filed (Month, Day, Year)	Peter	CARW:	no 7200 o	OB	Romen Bi	10 00	suta, k	0 25735

Division of Vital Records, P.O. Box 68760.

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		For State		State of M	aryland	•	artment of <i>rtificate o</i>		nd Menta		ene 1. No.2 0 (1 2	24976
_		Registrar 1. Decedent's Nam	e (First, Middle, L	ast)			Tillicate o	Deain	2. Da	Reg te of Death	. No. C U (7 ()	3. Time of Death
Physicia /Medic		Gerald		Lawson					Ju	onth Lv 24		′ear R	10:55A M
Examin				ive street and number))		4b. City, Town	, or Location of			4c. County of		10.55A
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ס		Usual Residence o			82		1		⊥ма	rch_	8,1926		Alabama
arylan show	<u>_</u>	10a. State	10b. County		10c. City,	Town or Lo	ocation					1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
the Mi	Director	Md. 10e. Street and Nu	PG		τ	Jpper	Marlh			100	a. Citizen of Wh	at Cour	
3a or	Ö			dia Lane						100			•
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or ite			ied 2 Married	1 □Yes 2 ☑ If Yes, Give	No		il res, specily C 1 □ Yes 2 🕱N		ruerto rican,	etc.)	Specify:	White,	etc.
tural"	ed by	3 XWidowed		Year or Dates:			dent's Usual Oc			1 46		Bla	
n "na	plet		15. Decedent's E	rade completed)		(Give life.	kind of work do DO NOT use ret	ne during most (ired)	of working	1	8b. Kind of Busi	ness/inc	austry
d with 'giene 'giene er tha	Completed	Elementary/Second 12	inuary (0-12)	College (1-4or !	5+)	Sale	es Clei	rk				Pri	vate
be filed within 72 hours after death with the Maryland the Hygiene. The Hygiene dither than "matural", or items 23a or 28a-f show event, the Madral Eventher must be notified.	Be	17. Father's Name	`					18. Mother	's Name (First,	Middle, Ma	iden Surname)		
Lal ylallo 4.14. 2 should be filled within and Mental Hygiene. is merked other than aumatic event, the M	၉	Judge 19a. Informant's N	Johnson			401 14 17		Min		ohns			
ie, intal yiality Z1Z1350030 s1 and 2 should be filed within 72 hours after death with the Marylan ff Healith and Memial Hygiene. ffem 27 is merked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be multiled at			nnson/bi	, ,,		1239	ng Address <i>(Stre</i> 9 . Delai	field 1			City or Town, S	tate, Zip	(Code)
Dearmit. Pages 1 and 2 Department of Health of Important: If item 27 is eny injury or other tragonce.		20a. Method of Dis	position	-	20b. Pla	ce of Dispo	ningtor psition (Name of matory or other p	nlace)	-20017		c. Location - C	ity or To	wn, State
Pages ment of ant: If its ury or o			☐ Cremation 3 [5 ☐ Other (Spec	☐ Removal from State ify)	1	500w	Cometa	2 m22 .	7/31/0	Ω	otroit	1.4	lichigan –
permit. Departit Importa eny inju		21. Signature of Fu	neral Service Lice	ppeee		2/	. Name and Ad	dress of Facility	Hodge	s &]	Edward	s F	.H.
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p ±	iner	if any, leading to im cause. Enter Under Cause (Disease or	nmediate erlying	Due to (or as	a conseque	nce of):	1						
be executed sician and burial-transit	Examiner	Cause (Disease or that initiated events resulting in death)	5	c. Due to (or as	a conseque	yro	ceme	9_				_	
sician buria				- 1	a conceque	1 00 01).							
or Attending Physician: The law requires that the death certificate baffer death certificate baffer death settle and the death certificate baffer death steer this certificate has been signed by the attending physic in by the funeral director, pege 2 should be detached for use as the b	Physician/Medical			d							1		
th cer tendir r use	an/N	IF FEMALE: 23b. Was deceden		23c. If yes, outcome 1 ☐ Live birth			☐ Ectopic pregna	ancv			23d. Date		•
ne dea the at	/sici	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify,				Mont	h	Day Year
that the ed by detacl				contributing to death b	out not resulti	ing in the u	nderlying cause	given in Part I.	23	se. Did toba	cco use contrib	ute to th	ne cause of death?
w requires that the di	d by									1 🗌 Yes	2 □ No 3	☐ Prot	pably 4 🗹 Unknown
aw rec	Completed								24	a. Was an	24b. We	ere auto	psy findings available
The lav ate has	mo.									autopsy performe ⊒Yes 2↓	ed]? de	or to co ath? ∃Yes	mpletion of cause of
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ding Physician; The in Affer this certificate h funeral director, pege	<u>٩</u>	1 Yes 2		Hospital: 1 ☐ Inpati		R/Outpatie	IL 3 L DOA				ce 6 Other	`,	y)
th. Afte	tion	1 Natural 2 Accident	5 Pending investigation	(Month, Da	ay, Year)	Injury		njuryat Vork? □Yes 2 □ N		escribe now	injury occurred	1	
After ar dea ector by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not l	28e. Place of Inj	jury - At hom tc. <i>(Specify)</i>	e, farm, str	l eet, factory, offic	ce	28f. Lo	cation (Stre	et and Number	or Rura	I Route Number,
Ital or rel Dir	Cert	- I Tottliede			ic. (opecity)				Cit	y or Town,	Siare)		
To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier (Check only one)	1 Certifying F	hysician: To the best miner: On the basis of and manner st	of examination	edge, deat on and/or in	h occurred at the vestigation, in m	e time, date and ny opinion, death	d place, and du h occurred at th	e to the cau ne time, dat	use(s) and man e and place, an	ner as s	stated. the cause(s)
To the To the comple	Mec	29b. Signature and				20 (29c. Lice	ense number		290	d. Date signed (Mgnth,	Day, Year)
		158	nglez	a Kesha	·· 1	11.1	1 1	0576	52		7/25	10	8
5		30. Name and add	ress of person who	completed cause of o							1		
Sta	te	Shylaja 31. Date filed (Mon	Keshav oth, Day, Year)	7, 5804 B	altin rar's Signatur	nore	Ave.,	Hyatts	ville	, Md.			
Registra		Al	JG - 4 20	08	, A	Ayra.	N. C.						
HMH 17 Rev 1/20	001			-		-							

		_ FOI	artment of Health and Mer rtificate of Death	ntal Hygiene
Physic		1. Decedent's Name (First, Middle, Last) Mary Catherine Meyer	2.1	Date of Death Month Day Year Uly 17, 2008 3. Time of Death 9:00 p
/Medi Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Funeral Director		Montgomery Hospice-Casey House 5. Social Security Number 6. Sex 1 □ M 2 □ F 89 Yrs. Usual Residence of Decedent	Rockyile If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min. M.	Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country) arch 12, 1919 Maryland
72 hours after death with the Maryland 'neturel', or items 23a or 28a-f show dical Examiner must be notified at	ctor	10a. State 10b. County 10c. City, Town or Lo	ocation y Spring	10d. Inside City Limits 1 ☐ Yes 27 No
with the	I Director	10e. Street and Number 1612 Hickory Knoll Road	10f. Zip Code 20860	10g. Citizen of What Country? USA
of z should be filed within 72 hours after death with the Marylar th and Mental Hygiene. 7 is merked other than "neturel", or Items 23a or 28a-f show traumetic event, the Medical Evaninar must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ X Never Married 2 □ Married 1 □ Yes 2 □ X No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- 14. Race - American Indian,
illed within 72 hour Hygiene. Wher than "neture ent, inc Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
and Mental Hygie is merked other t raumetic event, in	Be Co	17. Father's Name (First, Middle, Last)		rst, Middle, Maiden Surname)
should be it and Mental It is merked of aumetic ever	၉	Joseph F. Meyer 19a. Informant's Name/Relationship (Type. Print) 19b. Maillir		te L. Gadol oute Number, City or Town, State, Zip Code)
of Health a item 27 is other trau		Watson Leese/Executor 501	7 Sunflower Drive, R	ockville, MD 20853
perimit. rages I am Department of Heal Importent: If item 2 any Injury or other once.				y 21 20c. Location - City or Town, State Silver Spring, Maryla
Departr Importe any Inju			2. Name and Address of Facility. rancis J. Collins Fu 00 University Blvd.	
hysician and burial-transit the burial-transit	al Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Failure	Interval Between Onset and Death
ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
an signed by	by	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
	Completed			24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
this ce	on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	of 28c. Injury at Work? 28d	heck only one) 5 ☐ Residence 6 ★ Cherr (Specify) Hosp Describe how injury occurred
ctor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)	M 1 □Yes 2 □No reet, factory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
within 24 hours after To the Funeral Dire completely filled in b	ledical C	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.		
= 2 = =	a a	and maining stated.		
Vithin 2 To the comple	Me	29b. Signature/and title of certifier	29c. License number d64615	29d. Date signed (Month, Day, Year) July 18, 2008
44	Me	29b. Signature/and title of certifier 30. Nam and address of person who completed cause of death (Item 23a) (Type,	d64615 Print) uncaster Mill Road,	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Raymond Wavne Mohr /Medical July 18, 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery Olney If Under 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 XXM 2 □ F 213-76-9563 Yrs Director March 8, Washington, DC 1956 52 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Items 23a 320 Ednor Road 20905 Completed by Funeral USA 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Home Electronics permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event 20ce. 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Bernhard Smith Mohr Gertrude Jarvinen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Schaeffer/Partner 320 Ednor Road, Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State July 19 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blwd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular **Physician** /Medical Due to (or as a consequence of): Examiner りょくし if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Impertension
Due to (or as a consequence of): and the burial-tran Box 68760 physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) P.O. I ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? res 2 No

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, certificate

in by the funeral after death Director. To the Hospital within 24 hours a To the Funeral C

Be

Certification: To

Medical

25. Was case referred to medical examiner?

12 Yes 2 □ No

27. Manner of Death

1 Natural

2 Accident 3 🗌 Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier

filed (Month, Day, Year)

29a. Certifier

Hospital

2008

5 Pending investigation

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

State Registrar

Montgomery gistrar's Signature

29d. Date signed (Month, Day, Year)

9:23 p

10d. Inside City Limits

Approximate Interval Between Onset and Death

years

Day

Year

1 □Yes 2 □No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Print) 18101 Prince Phillip Orice General Hospital Olney, maryland 20832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholson

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 ☐ Yes 2 ☐ No

		. For	State of Maryland	/ Department		lental Hygien	e o o o	
	,	1 - Stete Registrer		Certificate		Reg. N	711118	24979
Physic /Medi		1. Decedent's Name (First, Middle, La E/12abeth	Catherine			07 24	ay O'8	3. Time of Death 1.23 PM
Examir	ner	4a. Facility Name (If not institution, giv			own, or Location of Death	م معاددات اوسی مرک	_	
Funeral Director		5. Social Security Number 6. S		st birthday) If Under 1	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Mgnth, Day, Yea 6/24/19/	9. Birth	pplace (State or Foreign untry) ington DC
death with the Maryland ms 23a or 28a-f show	7.	Usual Residence of Decedent 10a. State 10b. County Co. rx		Town or Location	ر مار			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the M 28a-f	recto	10e. Street and Number	~	Jest mir		10g. (Citizen of What Co	
th with 23a or unit be	ai Di	200 St. Luk	e Circle		21158		US	
ING KIKIDSO be filed within 72 hours after death with the Marylar stal Hyglene. Ind other than "natural", or items 23a or 28a-1 show event, the Madical Examinat must be confind at	by Funeral Director	11. Marital Status ¹ X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eventh U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		ent of Hispanic Origin? (Spr fy Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
72 hou	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Decedent's Usual (Give kind of work	Occupation done during most of work retired)	ing 16b.	Kind of Business/I	ndustry
within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Teacher	retired) -/ COUNSE	lor	Acad	omic.
IZITO Z	To Be Co	17. Father's Name (First, Middle, Last	i ali		18. Mother's Nam	e (First, Middle, Maid	•	yster
Alary 2 shou and N 1s mai	_	19a. Informant's Name/Relationship	/		Street and Number or Rur		or Town, Stat	Code)
Pages 1 and Pent of Health int: If Item 27 ary or other t		20a. Method of Disposition 1 □ Burjal 2 □ Cremation 3 □	nor nor	ce of Disposition (Name metery, crematory or oth	e of		Location - City or	7/15/
Daltimore, Maryla open; Pages 1 and 2 should Department of Health and Men important: If them 27 is marke any finury or other traumatic page.		4 □ Donation 5 □ Other (Speci 21. Signatur — suneral Service Lice CONA		State A	Address of Facility natomy Board	655 W. Ba	altimore	Street
n goesia		23a, Part N Enter the disease, occor	plications that caused the death.		re, MD 2120			Approximate
Physician		shock or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the death. one cause on each line.		art Dise			Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseque		4100			
Lxammer	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ence of):				
cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c					
/ bU, te be executed ysician and ne buriat-transit	cal Ex	resulting in death) Last	Due to (or as a conseque	ence of):				
Certificate of the last as the			d				Ī	
death death e atte	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 ⊟Ectopic pre			23d. Date of deli Month	very Day Year
Ords, F.C. requires that the een signed by th hould be detache	b	Part II. Other significant conditions Demen	1 6	ting in the underlying ca	use given in Part I.	23e. Did tobacc		the cause of death?
Te The la e has age 2	ompieted					24a. Was an autopsy performed:	prior to death?	topsy findings available completion of cause of
Or VICAL Physiclan: Tribis certificat ral director, p	Be C	25. Was case referred to medical examiner?	Hospital:			h (Check only one)		
Of Physical this control or th	. To	1 Yes 2 No 27. Manner of Death		P/Outpatient 3 DOA 28b. Time of 28	c. Injury at	me 5 Residence 28d. Describe how in		city) Hospice
VISION Attending pr death. rector: Atte by the fune	ation	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	n	Injury M	Work? 1 ☐ Yes 2 ☐ No			
LIVISION (tall or Attending Fis after death. al Director: After ed in by the funer.	Certification:	3 Suicide 6 Could not be determined		ne, farm, street, factory,	office	28f. Location (Street City or Town, Str		iral Route Number,
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai		nysician: To the best of my know miner: On the basis of examination and manner stated.					
To t To t	Σ	29b. Signature and title of certifier	MD		0006527		Date signed (Month)	
		30. Name and address of person who	completed cause of death (Item 2)	23a) (Type Print)				
St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 0 4 2000	7b chim 32. Registrar's Signatu	Gerle				

State Registrar

COLUINS P. SEIN, M.D.

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) AUG - 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D-46979

3460 OLD WASHINGTON RD. SUITE 203A WALDORF, MD. 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 855F CARRIE SINGLETON ${ t MURROW}$ 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** onen 8. Date of Birth (Month, Day, Year) 7/22/1914 5. Social Security Number Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Under 1 **Funeral** Months Days Hours Min 1 □ M 2**X** F 220-22-1007 94 **Director** Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD. Harford White Hall 10e. Street and Number 10g. Citizen of What Country? 2826 Troyer Road 21161 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No ģ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William J. Singleton Bertha ဥ Bulett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 Mary E. Akers (Daughter) 1443 Rock Ridge Rd. Jarrettsville, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once: Burial 2 Cremation 3 Removal from State 7/30/2008 Madonna, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Dluelder 100 Home, Jarrettsville, Maryland P.A. 23a. Part 1. Enter the disease, or complications that relised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each hine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE DEMENTIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 █ No Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2.2.No 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No by the 24 hours after deatle Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only within 2 29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) 10un

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

622

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

40

32. Registrar's Signature

DHANJANI

31. Date filed (Month, Day, Year)

HAVRE DEGRACE, MD21018

Please Type or Print in Black Indelible Ink. Ensure All Copies Are begible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 07/26/2008 5:10 А м Lillian C. Mills /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Talbot Hospice House Easton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 F nth, Day, Year) 03/02/1916 Maryland 92 217-03-4013 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other then "naturel", or Iteme 23a or 28a-f show any Injury or other treumatic event, the Musical Examinational Examinational Answers. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No Director Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29857 Peirce Way 21601 **USA** Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White 3€Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Alfred Cannon Linda Comegys ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29857 Peirce Way, Easton, MD 21601 Lois M. Peedin/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Red 4 Donation 5 Other (Specify) moval from State Entombment Dorchester Memorial Park 07/30/2008 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A., 308 High St., Cambridge, MD 21613 Rart 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearf failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examine burial-transi Division of Vital Records, P.O. Box 68760 Due to (or Physician/Medical attending physical for use as the b IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown ete has been signed by page 2 should be detect Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy 2 No 1 Yes 1 Yes 2 No To the Hospital or Attending Physicien: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ٩ 2 7 16 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending within 24 hours efter death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) In by 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Ex on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatur 29d. Date signed (Month, Day, Year) 29c. License number who completed cause of death (Item 23a) (Type, Print)

Registrar

State

30. Name and address of person

31. Date filed (Month, Day, Year)

AUG - 4 2008

DHMH 17 Rev 1/2001

Mitchell S. Gittelman, D.O., P.A., 31413 Winterplace Parkway, Suite 103 Salisbury, MD 21804

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** July 2008 OBAROWSKI 18. BERNICE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick
If Under 1 Year | If Under 24 Hrs. Frederick Frederick Memorial Hospital Birthplace (State or Foreign Country) (In vrs. last birthday) Social Security Number **Funeral** Hours Months Davs 86 188-14-1688 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State them 27 marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be retified at 1XYes 2 □ No Wilkesbarre Director Luzerne PA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 18705 1249 North Washington Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: <u>۾</u> White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cigar Mfg. Wrapper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H f item 27 Is marked oth Be Caroline Keck John Gallick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 513 Ellrose Court Frederick, MD 21703 Sandra J. Cadden Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State West Wyoming, PA St. Mary MaternityCm. 7-22-2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeeny & Basford P.A. F.H. 21. Signature of Funeral Service License 106 East Church Street Frederick, MD 21701 M01176 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumon a Physician a disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed as the burial transit and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical signed by the attending I IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months? 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been a al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 100 1 Yes 2 No 1 Tyes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica stelly filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 124 hours a completely filled Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

5

State Registrar Lapinong

JUL

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 8 2008 >

32. Registra 's Signature

Elena Iarikova M.D. 400 West 9th Street Frederick, Maryland 21701

D0065443

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🛭 🗎 🖯 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7:40 pm Patricia Pitsenberger Prins July 17 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) Days 1 □ M 2 🗷 West Virginia 69 235-62-3275 March 26, 1939 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Maryland** Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

20905

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ∐Yes 2 🗷 No

20b. Place of Disposition (Name of cemetery, crematory or other place)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director of Pharmacy

U.S.A.

White

Washington Adventist Hospital

Race - American Indian.

Specify

18. Mother's Name (First, Middle, Maiden Surname)

Augusta Olive Stone

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

General Hospital

2113 Sondra Court, Silver Spring, Maryland 20905

16b. Kind of Business/Industry

20c. Location - City or Town, State

filed withIn 72 hours atter death with the Maryland ed other than "natural", or items 23a or 28a-f show event, it is Medical Exercities at the restilled at Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "na any injury or other traumatic event, If a Pacific once. For State Registrar

11. Marital Status

2113 Sondra Court

15. Decedent's Education (Specify only highest grade completed)

Charles Ezra Pitsenberger

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Never Married 2 Married

3 X Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

David E. Prins - Son

12. Was Decedent Ever in U.S. Armed Forces?

1 ∐Yes 2 🛣 No If Yes, Give Year or Dates:

College (1-4or 5+)

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

2

Funeral

Director

show

Physician /Medical **Examiner**

physician and s the burial-trans attending pl been signed by the should be detached certificate has

Physician/Medical Examiner

Completed by

Medical Certification: To Be

Chhanbo 31. Date filed (Month, Day, Year)

or Attending Physician: The law requires that the death certificate be executed After this c funeral dire within 24 hours after death,

To the Funeral Director: A
completely filled in by the ft

Division of Vital Records, P.O. Box 68760

4 □ Donation 5 □ Other (Specify	")	Parklawn Memo	rial Park	07/25/2008	Rockville, M	faryland
21. Signature of Funeral Service Licen	Sacan	Hine		neral Home, Inc	c. Lver Spring, Ma	ryland 20904
23a. Part1. Enter the disease, or come shock, or heart failure. List only of Immediate Ca e (Final disease or condition	one cause on each line.	ne death. Do not enter the	ne mode of dying, such	as cardiac or respiratory	21 1 1-0	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a control of the co	consequence of): tailWP consequence of):	Injecti	en.	2 Weeks	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 NANo 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	☐ Fetal death 3 ☐ Ec	topic pregnancy her (specify)		23d. Date of del Month	livery Day Year
Part II. Other significant conditions or	ontributing to death but	not resulting in the under	lying cause given in Pa		tobacco use contribute to	o the cause of death?
				24a. Wa auto per 1 ∐Yes	opsy prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical examiner?				ace of Death (Check only		
1 Yes 2 No	Hospital:	2 ER/Outpatient 3	B□ DOA Other: 4□	Nursing Home 5 ☐ Res	sidence 6 Other (Spe	cify)
27. Manner of Death T Natural 5 Pending 2 Accident Investigation			28c. Injury at Work? M 1 □ Yes 2	28d. Describe	how injury occurred	
3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	r - At home, farm, street, (Specify)	factory, office	28f. Location City or To	(Street and Number or Ri own, State)	ural Route Number,
29a. Certifier (Check only one) Check only one) Certifying Ph 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner state	xamination and/or invest	curred at the time, date igation, in my opinion,	and place, and due to the death occurred at the time	e cause(s) and manner as e, date and place, and due	s stated. e to the cause(s)
29b. Signature and title of certifier	. M	D	D 65	715	29d. Date signed (Mont	h, Day, Year)

State Registrar Viontgomen

Registrar's Signature

			1- For Amend Item #8 State of Maryland / Depa State of Maryland / Depa State of Maryland / Depa Registrar WCHD/SH 7/25/08 per FH Cer	ortment of Health and Me tificate of Death	ental Hygien Reg. N	
	Physicia		1. Decedent's Name (First, Middle, Last) Paul Miller Roth	2	2. Date of Death Month July 20	3. Time of Death 6:37p M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 11815 Cadar Ridge Rd	4b. City, Town, or Location of Death		c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Williamsport If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth (Month, Day, Year	Vashington 9. Birthplace (State or Foreign Country)
	Director		215-26-8209	Months Days Hours Will.	5-31-19 5-13-1916	6 MD
	ryland how		10a. State 10b. County 10c. City, Town or Lo		<u>J-13-1910</u>	10d. Inside City Limits
	the Ma	ecto	MD Washington William	10f. Zip Code	100.0	1 □ Yes 2√ No itizen of What Country?
	th with 23a or	al Dir	11815 Cedar Ridge Rd.	21795		J.S.A.
36	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examiner must be notified at	by Funeral Director	1 Never Married 2♥ Married 1 TVYes 2 No TATAT T	Vas Decedent of Hispanic Origin? (Spec i Yes, specify Cuban, Mexican, Puerto R □ Yes 2 ☑ No Specify:	ify Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
altimore, Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Items 23a or 28a-f show svent. The Madical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of working DO NOT use retired) ry farmer	7	Kind of Business/Industry
land 2	2 should be filed and Mental Hygi is marked other raumatic svent.	To Be Co	17. Father's Name (First, Middle, Last) Daniel Roth	18. Mother's Name (Rosella	First, Middle, Maide Miller	n Sumame)
Man	iges 1 and 2 should to f Health and Men if Item 27 is marke or other traumatic			g Address (Street and Number or Rural 5 Cedar Ridge R		or Town, State, Zip Code) amsport MD 21795
imore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra once.			sition (Name of natory or other place) Ven Cem. Da July	25, Hag	Location - City or Town, State gerstown, MD
Balt	permit. Departr Importu any Inji		No mark A Fine D	Name and Address of Facility Onald Edwin Tho	mpson F	uneral Home, Inc
3			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or	respiratory arrest,	proximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a		^	YEATES
	Examiner	Examiner	Sequentially list conditions, if any, leading to minimalistic cause. Enter Underlying Cause (Disease or injury	funtive Disa	rde	yeaes
8760,	ate be executed thysician and the burial-transit	cai	that initiated events resulting in death) Last C. Due to (or as a consequence of): d.			
O. Box 68	he death certific the attending pi thed for use as t	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
rds, P.	w requires that ti been signed by should be detac	þ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
of Vital Records,	The law ate has b page 2 st	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vita	Physician: 1 this certificat ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	t 3 DOA Other: 4 Nursing Hom	. 1	6 □Other (Specify)
	ding After fune	atlon; T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Death (Month, Day Year)		3d. D scribe how in	
Division	al or Attendes after death	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str. building, etc. (Specify)	eet, factory, office	3f. Location (Street City or Town, Sta	and Number or Rural Route Number, tte)
	To the Hospital or Attan within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death one one one one one one one one one one	n occurred at the time, date and place, an vestigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the complete	M	29b. Signature and titleyof certifier Autulous	29c. License number MD 279	49 290.0	Date signed (Month, Day, Year) 50 (y 22, 2008)
ک	4-8		30. Name and address of person who completed cause of the (Item 23a) (Type, Stew Hatteberg 13424 Pennsylv	_{Print)} vania Ave, Suite 20	03,Hagers	town, MD 21742
<	Sta Registi		31. Date filed (Month, Day, Year) JUL 2 2 2008	book		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Hazel Louise Ray July 2008 9:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Casey House Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2 🗓 F 215-20-8289 Director 83 19. 1924 Virginia Nov. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland | Montgomery Germantown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 11817 Collins Drive 20876 USA Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🕅 No ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 12 banker banking is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Lester Sylvester Testerman Lacy Lee Damwood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Thomas Ray, husband 11817 Collins Drive, Germantown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7/19/2008 Alexandria, Virginia 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature of Funeral Service License 中 26401 Ridge Road, Damascus, Maryland iaukl. 23a. Part 1. In the disease, or complications that Laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or he at failure. List only one cause or each line. immediate C Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕅 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 2 \square No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: $_{4\,\square}$ Nursing Home $_{5\,\square}$ Residence $_{6\,\square}$ Other (Specify) Hospice 1 Tes 2 X No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. 2 Accident investigation i Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check o 29b. Signatur, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

W

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

State Registrar

DHMH 17 Rev 1/2001

1355 Piccard Drive,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Genieve Wroblewski,

31. Date filed (Month, Day, Year)

M.D.

32. Registra s Signature

General

D0064615

July 17, 2008

Rockville, Maryland

State of Maryland / Department of Health and Mental Hygiene rgiene Reg. No. 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician Ruben rwin ,2000 ub /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard County General Hospital Howard Columbia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Days 578-44-8996 May 3, Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 28a-f show 1 X Yes 2 □ No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'naturel", or items 23e or 10632 Hickory Crest Lane 21044 U.S.A. Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is merked other then College (1-4or 5+) Elementary/Secondary (0-12) Pharmacist Pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is merked otheny Injury or other traumatic event Be Albert Ruben Estelle Cohen ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, MD 21044 Kitty A. Ruben-Wife 10632 Hickory Crest Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 07/18/2008 | Olney, MD Judean Mem. Grdns. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170Rockville Pike Rockville, MD 21. Signature of Funeral Service Licensee 23a. Part I. Enter II & sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart tale. Immediate Cause (Final disease or condition resulting in death) **Physician** deles /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physicien: The law requires that the death certificate be executed physiclan and s the burlal-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Disectes is estilled 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Agrial dibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident neral Director: , filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier l 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 29b. Signature and of certil n who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 11055 Lid to Parcison P 31. Date filed (Month Day, Year) 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Sullivan 18:36 M 12 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bathmore, MV Under 1 Year I If Under 24 Hrs. University of Mayland Medical Center None 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Days Hours Director 224-54-4069 66 7, 1941 Virginia Sept. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified of once. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Carrol1 Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2237 Gillis Road 21797 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be John Melvin Sullivan Delma Madalyn Slagle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Sullivan / Wife 2237 Gillis Road Woodbine, Maryland 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 18 2008 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park Rockville, Maryland 21. Signature of 22. Name and Address of Facility Stauffer Funeral Homes, P.A.meral Service Licensee 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Complications of /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine relate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform rmed2 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No after death 2 Accident the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 79532 7/12/2008

Registrar

State

Justin

31. Date filed (Month, Day, Year)

Greene

5

32. Registra Signature

Bathmore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

2008

MD,

JUL 18

Slavin

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 4:35 P M Lenore Marie SCHRIEFER Julv2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Autumn Assisted Living Washington Hagerstown 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Months 82 June 1 1926 Director 152-20-8079 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Worldon Examination to most feel at 1 ☐ Yes 2 No Director Jefferson W. Va. Middleway 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 1590 Brucetown Road 25430 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. be filed within 72 hours after on the Hygiene.

I had hygiene. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🐼 No Specify: à White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If flem 27 is marked other tha any Injury or other traumatic event, I'm 1 once. Banker - Vice President Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Schriefer ပ Helen Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard Kennan - nephew 1590 Brucetown Rd. Middleway, W. Va. 25430 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory: 7/16/08 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYOCARDIAL when TOUTE LOFKERTICA disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown þ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4 | Johnknown 4POTHY (CID 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an cate has l page 2 s autopsy performed? 1 Yes 2 100 Hospital or Attending Physician: The certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 11001515 Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Dother} \) (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this LIVIN After this funeral o 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours a 'er death.

To the Funeral Lirector A
completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21.08 21801 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-5 31. Date filed (Mor State 2008 Registrar

			1 - State of Maryland State of Maryland Registrar		rtificate of D			giene Reg. No	- 7 11 11 5	3 24990	
	Physici	an	1. Decedent's Name (First, Middle, Last) Lorraine Rhodes Seal				2. Date of De Month July	De	ay 2008	3. Time of Death	
	/Medio	cal	Lorraine Rhodes Seal 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death		18	c. County of Dear	4:35 P M	
7	EAdiiii	lei	Golden Living Center		Hager				Washington		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıy, Year	9. Bir	thplace (State or Foreign ountry)	
	Director		217-32-5883 74 Usual Residence of Decedent				Dec.16	, 19.	22	Maryland	
	arylan show ed at	J.	10a. State 10b. County 10c. City, 1	Fown or Lo	cation					10d. Inside City Limits 1XXYes 2 □ No	
	the M 28a-f notifie	Director	Maryland Washington 10e. Street and Number	W	10f. Zip Code	rt	T	10g. C	itizen of What Co		
	th with 23a or ist be	al Di	128 N. Conococheague St.		21	795			1	ISA	
	er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of His f Yes, specify Cuban		pecify Yes or No o Rican, etc.))-	14. Race - Ame Black, Whit	erican Indian,	
336	urs afte	þ	1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:			Specify:	White	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notifiled at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decec	dent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of wor	king	16b. I	Kind of Business		
121	within ene. than "	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired) Manage				Video	Sales	
	other other oent, th	Be Co	17. Father's Name (<i>First, Middle, Last</i>)			18. Mother's Nan	ne (First, Middle	, Maide		00100	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To E	Charles Harris Hill Ardinger			Velma	Lenora	Rho	odes		
Mar	d 2 sh th and 7 Is m traum				g Address (Street ar						
	s 1 and 2 if Health Item 27		20a. Method of Disposition 20b. Plac		sition (Name of matory or other place)		Date Date		ocation - City or	lary land 2179 Town, State	
Baltimore,	20a. Method of Disposition 10. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Burial Service Livenses 20b. Place of Disposition (Name of cemetery, crematory or other place) Green lawn Mem. Park July 23,2008 of State of Disposition (Name of cemetery, crematory or other place) 21. Signature of Burial Service Livenses 22b. Place of Disposition (Name of cemetery, crematory or other place) 3 Creen lawn Mem. Park July 23,2008 of State of Disposition (Name of cemetery, crematory or other place) 22b. Place of Disposition (Name of cemetery, crematory or other place) 3 Creen lawn Mem. Park July 23,2008 of State of Disposition (Name of cemetery, crematory or other place)							Wi	lliamspo	ort.Maryland	
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Englad Service Livenson	08	Borne and Address	eragiity Hon	ne, P.A.				
	202 00		23a. Part1. Enter the disease, or complications that caused the death.		5 S. Conocer the mode of dying				iamsport	Annroximate	
9	Physician		shock, or Yeart failure. List only one cause on each line. Immediate Pause (Final disease or condition	IMO	Carei	MAM O				Interval Between Onset and Death 3 Monla	
	/Medical Examiner		resulting in death) Due to (or as a consequent	nce of):	90101	10011				3 / (0 / (0)	
B	× 4	e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequent	nce of):							
	cuted nd ransit	Examiner	Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
60,	be execian a		resulting in death) Last Due to (or as a consequent	nce of):							
68760,	tificate be executed g physician and as the burial-transit	edical	d								
Вох			IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal december 1 □ Live birth 2 □ Fetal december 1 □ Live birth 2 □ Fetal december 2 □ F		Ectopic pregnancy				23d. Date of de		
	The law requires that the death cer the has been signed by the attendir hage 2 should be detached for use	Physician/N	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown		Other (specify)				Month	Day Year	
, P.O	res that the de signed by the a be detached i		Part II. Other significant conditions contributing to death but not resulting	ng in the u	nderlying cause giver	n in Part I.	23e. Did	tobacco	use contribute to	o the cause of death?	
rds	w requires been sign should be	ed by					12	Yes 2	2 □ No 3 □ P	robably 4 □Unknown	
Vital Records,	has be	Completed					24a. Was	psv	prior to	utopsy findings available completion of cause of	
tal F			25. Was case referred to medical					ormed? 2 N	death? lo 1 ☐ Yes	3 2 □ No	
r V	ysicia is cert directo	To Be	examiner?	R/Outpatien	Othor	26. Place of Dea			6 ☐Other (Spe	acifv)	
n or	ding Ph h. After th funeral		1 Natural 5 Pending (Month, Day Year)	8b. Time of Injury	Work?	at	28d. Describe				
Division	death.	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home	e, farm, str		es 2 No	28f Location /	Street a	and Number or R	ural Route Number,	
Div	s after al Dire	Certification:	4 Homicide determined building, etc. (Specify)				City or To			ara risate riambor,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director.	Medical (29a. Certifier (Check only one) (Check only one) (Check only one)	edge, deat	n occurred at the time vestigation, in my op	e, date and place inion, death occu	e, and due to the urred at the time	cause(, date a	s) and manner a	s stated. e to the cause(s)	
	o the vithin 2 o the comple	Med	one) and manner stated. 29b. Signature and title of certifier		29c. License	number		29d. D	ate signed (Mon	th, Day, Year)	
	- / - 0		Maujen grag		D28	365		7-5	91-08		
0 4	11-7		30. Name and address of person who completed cause of peath (Item 2.	3a) (Type,	Print)	treat-	- Hear-	1.	91-08 w 217	(, ,	
0	州-ス Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatur		uill &	1 veet	rege	seen	w 2(1)	70.	
	Regist		JUL 2 2 2008	J. A	Coaste 2						

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** CARRIE SELESNICK 2008 JULY 3:38p 16, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SUMMERVILLE ASSISTED LIVING POTOMAC MONTGOMERY If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕱 F 14, 83 FEB 1925 PA Director 202-16-2869 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show or than "natural", or items 23a or 28a-f shortham Medical Examinar must be notified at 1 XYes 2 No Director MARYLAND | MONTGOMERY **POTOMAC** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 11215 SEVEN LOCKS ROAD #210 20854 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 ∐XNo Specify: WHITE Specify: 2 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) $\tilde{1}\tilde{2}$ SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic ev HENRY HERBENER PAULINE DUDECK 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MANNY MILLER/SON-IN-LAW 8317 SNUG HILL LANE, POTOMAC, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State NORBECK MEML PARK 07/18/2008 4 ☐ Donation 5 ☐ Other (Specify) OLNEY, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. Donald 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Approximate Interval Between Onset and Death 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition **Physician** PANCREATIC CANCER disease or condition resulting in death) LESSTHAN 6 mo. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of) Box 68760 attending physician certificate be Physician/Medical as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Por Month Day Year 5 ☐ Other (specify) □Yes 2X No o the 9 Unknown 9 Unknown ٣. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ ATRIAL FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 XNo 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To the Hospital or Attending Physic within 24 hours after death.
To the Funeral Director: After this occompletely filled in by the funeral director. Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{X} \) Other (Specify) Hospital: 1 Yes 2 XNo ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X☐ Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35996 JULY 17, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2730 UNIVERSITY BLVD #400, WHEATON, MARYLAND DR. LINDA M. BURRELL. 20906

State Registrar 31. Date filed (Month, Day, Year) JUL 18





			For State Registrar	State of Maryland			of Health ar	nd Mer	ntal Hygiene Reg. No	4000	24992
I	Physici		1. Decedent's Name (First, Middle, Las Crystal Creech S						Date of Death Month Day	y Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	· · · · · · · · · · · · · · · · · · ·	te.	4b. City, To	own, or Location of I		- 4 1	County of Deat	
	Funeral Director		5. Social Security Number 6. Security Number 1		st birthday) Yrs.	If Under 1 Months		Min.	Date of Birth (Month, Day, Year)	Co	hplace (State or Foreign untry) th Carolina
	aryland show	70	Usual Residence of Decedent 10a. State 10b. County		Town or Lo	cation					10d. Inside City Limits 1y☐ Yes 2 ☐ No
	the M	recto	NC Wake 10e. Street and Number	Ral	eigh	10f. Zip C	Code		10g. Cit	izen of What Co	
	th with 23a or	ai Di	6402 English Oak	Drive		276				USA	
36	be ilied within 72 hours after deeth with the Maryland Hygiene. d other than "natural", or itsms 23a or 28a-f show svent, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ⅓ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Deceder I Yes, specif I ☐ Yes 2	nt of Hispanic Origin y Cuban, Mexican, I No Specify:	n? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race - Ame Black, White Specify: R1	
2-00	72 hour	sted b	15. Decedent's Ed (Specify only highest grav	ucation	16a. Deced	dent's Usual	Occupation	of working	16b. K	ind of Business/	
Maryland 21215-0036	within piene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		oo NOT use torney	done during most o retired)		T.A	w Firm	
ng	be filed ital Hygid d other svant, it	Be	17. Father's Name (First, Middle, Last) Roger Creech				18. Mother's		irst, Middle, Maiden		
<u> </u>	should be and Mental marked o umatic svs	٦.	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	ng Address (Street and Number	or Rural Ro		or Town, State, 2	Zip Code)
	s 1 and 2 should if Health and Men Itsm 27 Is marke other trsumatic		Edward Shepherd	/Spouse	6402	Englis	sh Oak Dr		-		
ore	Pages 1 nent of He ant: If itsn ury or oth		20a. Method of Disposition 1 □xBurial 2 □ Cremation 3 🔯	Removal from State	ce of Dispo	sition (Name natory or oth	e of er place) al Garden	Date		son, NC	
Baltimore,	permit. Pages Department of Important: If II any Injury or o		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen						hall's Fu		
	40 E # 9		23a. Part. Enter the disease, or comp	olications that caused the death.			h. St. N.			, D.C.	20011 Approximate
	Physician		sheck, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line.			Cardior			TDi	Interval Between
1	/Medical Examiner		resulting in death)	Due to (or as a conseque				-63 654	72-0 // 40	W 013	
	be tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseque	nce of):						
o,	certificate be executed iding physicien and ise as the burial-transit	Examiner	that initiated events resulting in death) Last	C Due to (or as a conseque	nce of):						
68760	licate be physical s the bu	edicai	•	d							
Ď.	death e atter	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3	Ectopic prec Other (spec				23d. Date of deli Month	ivery Day Year
rds, P	The law requires thet the the hes been signed by th rage 2 should be detache	d by Pr	Part II. Other significant conditions co	ontributing to death but not result	ing in the ur	nderlying cau	use given in Part I.				the cause of death?
		Completed							24a. Was an autopsy performed?	prior to death?	ntopsy findings available completion of cause of
Vital	delan: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Othor		heck only one)		
ō	g Phys er this eral dii	n: To	27. Manner of Death	1 Inpatient 21 E	VOutpation 8b. Time of		c. Injury at Work?		5 Residence Describe how inju		cify)
Division of	or Attending F ter death. Irector: After In by the funera	catio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Injury	М	1 Yes 2 No				
<u>></u>	T a s d	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	eet, factory,	office	281.	Location (Street ar City or Town, State		iral Houte Number,
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medicai	29a. Certifier (Check only one)	ysician: To the best of my knowle liner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at vestigation, in	the time, date and n my opinion, death	place, and occurred a	due to the cause(s at the time, date and) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the complex	Σ	29b. Signature and title of certifier	10-to		29c.	License number	2	29d. Da	te signed (Monti	h, Day, Year)
1	0		30. Name and address of person was	completed cause of death (Item 2	3a) (Type,	Print)	0007	1/	JU	7 16	2000
,			SALVADOR SILV	STEP 3001 Ho	spit	al I	Drive, (Chove	end, Mo	ing a	مر
	Sta Registr		31. Date filed (Month, Day, Year) JUL 18 200	3 Registrar's Signatu	Sp.	WE T	•		<i>V1</i>	/	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Gary Leonard Smith July 15, 2008 7:06 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 ★ M 2 □ F Director 57 Jan. 30, 1951Pennsylvania 183-42-8637 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at 1XYes 2□No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9900 Blundon Drive Apt. 101 20902 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify à Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Client Service Coordinator NPR Radio 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည John Smith Marie Sims 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tra 213 McDonald Blvd. Aliquippa, PA 15001 Gwendolyn Moore / Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ※ Removal from State 4 □ Donation 5 □ Other (Specify) Woodlawn Mem. Park July 22, 2008 Aliquippa, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. 1 me 7400 Georgia Ave., N.W. Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardio Pulmonary Arrest /Medical Due to (or as a consequence of) Examiner Acute on Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Pauci Immune Vasculitis burial-trar Due to (or as a consequence of): the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) After this certificate has been signed by the ifuneral director, page 2 should be detached 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Completed Pneumonia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2K No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No ٥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 X Natural 5 Pending investigation 1 Yes 2 No s after death. 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and little of certified 29c. License number 29d. Date signed (Month, Day, Year) D065069 July 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sirak Lemma 1500 Forest Glen Rd. Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 **Physician** Carolyn Davis Self 16 2008 22:01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/27/1936 Birthplace (State or Foreign Country)
_ 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 71 D.C. Director 577 54 2179 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show an "natural", or Items 23a or 28a-f shov Medical Examiner must be notified at 1 K Yes 2 □ No Director MD Prince Georges College Park 10f. Zip Code 10g. Citizen of What Country 10e Street and Number 9215 Davidson Street 20740 United States 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 ☐ Yes 2**X**] No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Childrens Hospital Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other that any Injury or other traumatic event, the N NURSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Ellsworth Davis, Sr. Theima Marshall ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9215 Davidson Street College Park, MD 20740 Geoffrey Davis, Sr. SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 NBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from Lincoln Memorial Cem. 07/25/2008 Suitland, Maryland 22. Name and Address of Facility John T. Rhines Funeral Home, LLC Funeral Service 3005 12th Street NE Washington, DC 20017 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final Physician ease or condition ulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t I be detach significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 3 Probably 4 Unknown 2 □ No T⊢ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 20 No certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🔲 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Munny of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Watural Injun 5 ☐ Pending investigation To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier

(Check only one)

29b. Signature and litle of certifier

Kango Narseen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical

7701 Carroll Ave Takoma Park, Maryland 20912

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

29d. Date signed. (Month. Dav.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10:45 a^M JULY 18. 2008 LEON SCHARFF /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CASEY HOUSE MONTGOMERY ROCKVILLE ROUCK VILLE
If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. NOV 21, Birthplace (State or Foreign Country)
 NEW YORK 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Vear! 1 ☑ M 2 □ F 1920 87 Director 052-12-6437 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director MARYLAND MONTGOMERY SILVER SPRING 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with ò 20902 11105 NICHOLAS DRIVE USA 23a Funeral tems 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after Yes 2 fYes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 ò Specify: WHITE 1 ☐ Yes 2 🖾 No Specify: \$ 3 X Widowed 4 ☐ Divorced Year or Dates: WWII "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) ELECTRICAL ENGINEER U.S. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAY SCHARFF DORA MARGOLIES ၉ 19a. Informant's Name/Relationship (Type. Print)
JOSHUA E. SCHARFF/SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is 1 any injury or other traul once. 4600 HARLAN STREET, ROCKVILLE, MARYLAND 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 X Removal from State MT. HEBRON CEMETERY 07/20/2008 FLUSHING, NEW YORK 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility EDWARD SAGEL_FUNERAL DIRECTION, 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part 1. Enter the disease, or complications that caused the sath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi and Due to (or as a consequence of): 68760 physician certificate be Physician/Medical the use as Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy requires that the death ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No Ö the 9 Unknown 9 Unknown ğ ۵. nas been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC RENAL DISEASE 24a. Was an autopsy page certificate I 1 ☐ Yes 2X No 1 □Yes 2 □ No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\overline{\text{NOther (Specify)}} \) HOSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1X Natural injury 5 | Pending Jr At. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in t Hospital To the Hospital within 24 hours a To the Funeral I completely filled 29a, Certifie 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0064165 JULY 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GENEVIEVE WROBLEWSKI, 6001 MUNCASTER MILL RD, ROCKVILLE, MARYLAND 32. egistrar's Signature 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar		artment of Health and M	lental Hygier	211118 21.996		
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death		
	/Medic		Joseph T. Shanko			July 19,			
	Examin	er	4a. Facility Name (If not institution, give street an		4b. City, Town, or Location of Death		4c. County of Death		
			Washington Adventist 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Takoma Park If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery 9. Birthplace (State or Foreign		
	Funeral Director		526-70-4307		Months Days Hours Min.	(Month, Day, Yea June 28.	ar) Country)		
	ס		Usual Residence of Decedent			oune 20,			
	arylar show	_	10a. State 10b. County Maryland Montgom	10c. City, Town or Lo	r Spring		10d. Inside City Limits 1 ☐ Yes 2 🔀 No		
	Be-f	Director		ely Silve		10-			
	e or		10e. Street and Number 10503 S. Dunmoor Dr	ive	10f. Zip Code 20901	109. 1	Citizen of What Country? USA		
	in 72 hours after death with the Maryland "netural; or Items 23e or 28e-f show kallgal Exercited from the Indiffied at	Funeral				ecity Yes or No-	14. Race - American Indian,		
(0	r Iten	Ξ	1 ☐ Never Married 2 ☐ Married 1 ☐ Y	res 2 □ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.		
03	ral', o	i by	3 Widowed 4 Divorced Year	or Dates: Vietnam	1 ☐ Yes 2 ☐ No Specify:		Specify: White		
21215-0036	72 h	Completed	15. Decedent's Education (Specify only highest grade comple	ted) 16a. Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b.	. Kind of Business/Industry		
121	within and the state of the sta	du	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)	<i>DO NOT use retired)</i> ystems/Program Ana		Tm =		
	Hygint, I	e Co	17. Father's Name (First, Middle, Last)	2 5		e (First, Middle, Maid	Insurance		
an		To Be	Adam Joseph Shanko		Clare	Ann Galla	gher		
Maryland	2 should be and Mental is marked o	-	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Run				
	rtr		Maureen Shanko/Wife	105	03 S. Dunmoor Driv	e, Silver	Spring, MD 20901		
ore	ges 1 au t of Hea if item or othe		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal	20b. Place of Dispo	osition (Name of	20c. 11y 28,	Location - City or Town, State		
Ë	Pag ment ent: I		'4 □Donation 5 □Other (Specify)	Gate of	Heaven Cemetery	2008 S	ilver Spring, Marylan		
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licensee		2 Name and Address of Facility rancis J. Collins 00 University Blvd		lome Inc. lver Spring, MD 2090		
No. of the last of	Physician // / / / / / / / / / / / / / / / / /	Examiner	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cluse Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	or respiratory direct,	Approximate Interval Between Onset and Death				
Vital Records, P.O. Box 68760,	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	e Completed by Physician/Medical	Part II. Other significant conditions contributing Contribution 25. Was case referred to medical	Pregnant at time of death 5[Jnknown		23e. Did tobacc 1 ☑ Yes 24a. Was an autopsy performed 1 □ Yes 2 ☑ h (Check only one)	24b. Were autopsy findings available prior to completion of cause of death?		
	y s	0	examiner? 1 ☐ Yes 2 ☑ No Hospital:	1 🗷 Inpatient 2 🗌 ER/Outpatier	Othors		e 6 □Other (Specify)		
n of	ding Ph h. After thi funeral	Ju: T	27. Manner of Death 1 ▼Natural 5 □ Pending	Date of Injury 28b. Time of Month, Day Year) Injury		28d. Describe how in			
Siol		atlc	2 Accident investigation		M 1 Yes 2 No				
Division	in Pire	Certification:	determined 280.	Place of Injury - At home, farm, stouilding, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)		
	Fur 4 Bey	edical ((Check only 2 Medical Examiner: On		h occurred at the time, date and place, vestigation, in my opinion, death occur				
	To the within 2 To the complet	Me	29b. Signature and title of certifier) (0	29c. License number	29d. I	Date signed (Month, Day, Year)		
7	le el) PPI O	- 2161	D4560		7-19-08		
L	~~		30. Name and address of person who completed	cause of death (item) 23a) (Type,	X CN, #124,	BOCI,	ie, MD 20115		
	Sta Registr		31. Date filed (Month, Day, Year)	32 degistrar's Signature	anti)				

State of Maryland / Department of Health and Mental Hygien 2008

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 18, **Tydings** July 2008 11:15A Evelyn Stuckert /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville 715 Maiden Choice La. 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🖾 F Yrs. 577-09-0341 Apr. 13, 1916 Washington D.C. 92 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. Count r than "natural", or items 23a or 28a-f show tre Modical Examiner must be notified at 1 XYes 2 No Director Baltimore Catonsville Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21228 715 Maiden Choice La. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Secretarial Executive Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pe and Mental permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Ia marked any injury or other traumatic ev 9068: V. Carrick Harriet Rufus M. Tydings 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Evelyn T. Stuckert (Self) 715 Maiden Choice La. Catonsville, Md. 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Chambers Crematory July21,2008 Riverdale, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Chambers Funeral Home & Crematorium, P.A. hams 5801 Cleveland Ave. Riverdale, Md. 20737 Shomas Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Humig usta Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4-Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 Yes 2 ₹No certificate 1 Yes After this certification, funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Tyes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending To the numbers after death, within 24 hours after death.

To the Funeral Director: Aft 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catonsvillo Masla (4255 711 maide Choice Lano nu 31. Date filed (Month, Day, Year) . Registrar's Signature State 21 2008

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 U U 8 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Virginia July 17,2008 6:12p Spivey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 443-10-3333 Months 1 □ M 2 🔀 F 90 11/30/1917 Oklahoma Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

In properties 17 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wodgal Event or it unto be conflicted any lourge. S.C. Horry Myrtle Beach 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5001 Little River Road #W501 29577 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify þ 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Franklin McCaleb Marguerite Swartz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael R.McCaleb/Nephew Tisberry Mill Court Gaithersburg, Md20877 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 7/21/2008 Beltsville, Md 4 ☐ Donation 5 ☐ Other (Specify) FHILIP Addes TINALDI FUNERAL SERVICE, P.A. ILL 9241 Columbia bLvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death 5 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Failute to thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ne The law requires that the death certificate be executed nding physician and use as the burial-transit Exami resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No atten for us 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown chronic obstructive lung disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an coronary artery disease autopsy performed? 1 ☐ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1∐Yes 2⊠No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t I or Attending Fafter death. To the Hospital or Attenuing within 24 hours after death.

To the Funeral Director: Aft 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0062435 July 18,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 10110 Molecular Dr. Rockville, Md 20850 Sayeo Eisayyao egistrar's Signature Year 2 31. Date filed (Month) Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 10 8 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) 6. Sex Months Days Hours 1 M 2 X F 81 577-38-7650 August 14, 1926 Ohio Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c City Town or Location 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3352 Chiswick Court, #1G 20906 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🏲 No Specify 3 N Widowed 4 Divorced Caucasian 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Scarlett Austin Gienger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8441 Mountain Laurel Lane, Gaithersburg, Maryland 20879 Janette M. Van Meers - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State George Washington Cemetery 07/25/2008 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hour ut disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗆 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 ☐ Yes 2 5 12 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Physician

/Medical

Director

Funeral

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Completed

Be

2

Examiner

Funeral

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, Ire Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examines and.

Saltimore, Maryland 21215-0036

the Maryland

death with

Examiner the ils certificate has been signed by director, page 2 should be detach After this in 24 hours after death.
The Funeral Director: Af

Hospital or Attending Physician: The law requires that the death certificate be executed

24g P ハンハイ・ Division of Vital Records, P.O. Box 68760,

Physician/Medical ģ Completed Be Certification: To

Medical

State Registrar 29a, Certifier

(Check only one)

29b. Signature and title of certifier

3 ☐ Suicide 4 Homicide

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29d. Date signed (Month, Day, Year)

Research BLVD 40

31. Date filed (Month, Day, Year)



within 2

2 2

State of Maryland / Department of Health and Mental Hygien 2 0 0 8 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** JULY 10, Year 2008 CARL DELANO \mathbf{P}^{M} SMITH 5:20 /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Capitol Heights Prince George's 1210 Boones Hill Road #4 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F Yrs 577-46-7612 Director August 22, 1935 Washington, Do Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or iteme 23a or 28a-f ehow adical Examiner must be notified at Marvland Prince George's 1 Yes 2 □ No Capitol Heights Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1210 Boones Hill Road #4 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural" or intermediate of the Indian of the Indian of the Indian of Indian or Indian of Indian or Indian o 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No β Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Truck Driver Private (Safeway) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gerald Smith ဥ Alice Warrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Smith - Wife 1210 Boones Hill Road Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Maryland Vet's Cemt. July 21, 2008 Cheltenham, MD 4. □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. ature of Funeral Service Licen 21. Si 4001 Benning Road, NE Washington, DC 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC PROSTATE CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 8 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? this certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ^o 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation s after death.
Il Director: Aft
id in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai To the h and manner stated. 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD# 33255 July 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAREN ANN BLACKSTONE, M.D., VAMC 50 IRVING STREET NW, WASHINGTON, DC 20422/688 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 2 2 2008